

FUNDAMENTAL *Psychiatry*

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PREFACE

The modern world is witness to many strange anomalies. Perhaps the strangest is the spectacle of a new science, psychiatry, without a "psyche"—the curative treatment of the soul, without a soul.

Extended experience in teaching psychiatry has made it increasingly apparent to us that it is no longer possible merely to point out the deficiencies in existing texts, and thus hope to fill out the full picture of mental disorders, their symptoms, analyses, and therapy. There is a definite and pressing need for an organized presentation of psychiatric studies which is duly based on the full and adequate picture of human nature. That is what we propose in the following text.

If there seems to be a too urgent insistence on the antimaterialistic aspect of psychiatry, it is only because there must be some kind of adequate counteraction against the weight of materialistic thinking in the field.

The point of view established and maintained throughout this text is not the materialistic deification of the soma; it is not the Neoplatonic scorning of all matter; it is rather the middle course established long ago by the Aristotelico-Thomistic fusion of matter and spirit in man into one complete, bewildering, complex, dynamic reality, the human person.

The student would do very well to keep in mind that the insistence on the spirit in this work is not a blind harkening to what is contemptuously referred to as "the outmoded theological prejudice called 'soul,'" by those who are unscientific enough to close their eyes to incontrovertible evidence. He must remember that certain objective, scientifically observable phenomena in the realm of the human person are admittedly beyond the reach of human explanation unless there is a spiritual entity to explain them. It is not sufficient, nor scientific, to turn one's head from that section of reality, and solve the problem merely by denying its obvious existence. More or less deliberate blindness or contempt has added little to the deposit of human knowledge.

The work presented here is by no means complete; knowledge of the absorbing thing called man will continue to grow. It is hoped,

however, that the organization of this matter will furnish the foundation for further investigation; that the fusing of a materio-spiritual philosophy with the science of psychiatry will offer new and unsuspected riches in knowledge of human behavior.

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In reading this material, the student should bear in mind that its basic concept and form of expression are probably different from those to which he has been accustomed in reading psychiatric literature. This has been done deliberately. We feel that there is nothing incompatible between the teachings of scholastic philosophy and modern psychiatry, and for this reason as well as to emphasize this point, we have couched our descriptions more in philosophical terms than in the usual psychiatric terminology.

The case reports have been chosen where possible to show the longitudinal nature of the disorder rather than the horizontal. We feel that this is more instructive. Many of the cases, therefore, have been selected from the archives before the institution of modern therapy because we feel the cases so selected show the natural course of the disease rather than its alteration by modern therapy.

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PART I

INTRODUCTION TO PSYCHIATRY

CHAPTER

- I. INTRODUCTORY CONCEPTS
- II. THE EXTENT OF MENTAL DISORDERS
- III. MENTAL HEALTH AND THE NORMAL PERSONALITY

INTRODUCTORY CONCEPTS

The importance of psychiatric concepts, previously recognized by relatively few, has been brought sharply into focus by the result of Selective Service examinations during World War II. As a result, psychiatry, instead of being an isolated specialty, became an important branch of general medicine. Seven hundred thousand men, or 16.5 per cent of the total number examined by Selective Service, were rejected from the draft because of nervous and mental disorders. Another 582,000 (13.8 per cent) were rejected for other reasons, including mental defects. Although the figures are not complete, almost 45 per cent of those discharged from the Army for disability were dropped for psychiatric reasons.

The realization of the enormity of the problem has brought about a surge of activity and a marked new interest in mental health. During World War II, the Mental Hygiene Program gained momentum with the appreciation that there are laws of mental health. There is no longer any doubt that the widest possible publicity should be given to the facts of mental life. No professional student should be allowed to complete his training without a good understanding of psychiatric concepts.

Unfortunately, it is not easy to obtain the desired knowledge. Many of the manuals which give elementary instruction in mental disorders are imperfect, chiefly because they are based on a materialistic philosophy of man and life. Knowledge obtained from such a source is at best and of necessity partially inaccurate and at least potentially harmful.

Two motives prompt the present contribution: (1) a desire to present the facts of mental abnormality from a dualistic, mind-body approach and not from a materialistic point of view; and (2) a desire to present a simple, unified picture of the contribution of abnormal psychology, mental hygiene, and psychiatry in a manner sufficiently simple and compact to be readily grasped by the average student.

It may help toward clarity to define (1) psychiatry, (2) abnormal psychology, (3) mental hygiene.

1. *Psychiatry may be defined as that branch of medical science which treats of the tendencies, development, characteristics, care, and cure of people afflicted with mental disorders.* The emphasis in psychiatry is practical rather than theoretical. Its main purpose is the understanding, treatment, care, and cure of the mentally ill people. Psychiatry, therefore, presupposes mental abnormality and formulates principles, techniques, and therapies to beget psychic normalcy in the life of the individual.

Bonnell writes:

Psychiatry is derived from two Greek words "psyche" and "iatreia." The usual translation of the former, "mind," happens to be not the primary meaning of the word but the third in the order in Liddell and Scott's *Greek Lexicon*. There the word is defined in the following order: I. "Breath, especially as the sign of life, life, spirit." II. "The soul of man, as opposed to body." III. "The soul, mind, reason, understanding." The word psychiatry then means primarily "the healing of the soul of man," as opposed not only to the body, but also to the mind, reason and understanding.¹

Psychiatry in its amplitude further envisages the training of the will, the formation of good habits and character, the transformation of psychic dissociation into a dynamic synthesis of the entire personality, the formation of the whole man. From its definition it is obvious that psychiatry properly so called is based on dualism, mind-body, and assumes the responsibility of diagnosing and curing the mental abnormalities of man perennially recognized as a being composed of a body and a soul. Psychiatry lacks its true meaning and office in the setting of modern materialistic philosophy where the goal of man's essence, nature, and aspirations is pithily summarized in one short sentence: "Dust thou art and into dust shalt thou return."²

In man we have to reckon with vegetative, sensory, and rational elements which interact or exert mutual influence. That the discussion of man's psychic life may be complete, it is necessary that his various constitutive elements be known and examined and their interrelation indicated wherever it exists. This neither materialism nor psychiatry, if it be based on materialism, can ever hope to achieve. The statue of Nabuchodonosor quite high and foreboding had a head of gold, breast and arms of silver, belly and thighs of brass, legs of iron, and feet part of iron and part of clay.³ There is no gold, silver, brass, or iron in the statue raised to materialism. It is completely, totally, and entirely of clay.

Hence, it is evident that psychiatry to be true to its name, definition, and goal must be based on the mind-body combination, on dualism, with the necessary implications of soul, mind, will, and emotions.

2. *Abnormal psychology is that branch of psychological science which studies the nature and causes of mental abnormality.* The emphasis in abnormal psychology is speculative rather than practical. Therapies are not stressed.

3. *Mental hygiene is that branch of psychology which, on the basis of findings gathered from various sources, endeavors to understand and prevent mental distortions and develop sound personality.* Mental hygiene, just as psychiatry, is eminently a practical study. As it is ordinarily presented it pays special attention to the neuroses.

PREVIOUSLY FORMED ATTITUDES

Individuals approaching the study of mental disorders are deeply influenced by their previously formed philosophy of man. Psychiatry presupposes or takes for granted vast areas of knowledge belonging to allied fields. An engineer relies greatly on principles of mathematics and physics. He does not question the bases of the sciences themselves but accepts their findings as thoroughly established and valid. To him they are usable truths.

A lawyer is influenced by the moral code he has previously accepted. If he himself does not accept the fundamental tenets of justice, such as "Thou shalt not steal," he may use his legal knowledge to great personal economic advantage, even at the expense of his clients. If he accepts the basic precept of honesty laid down by the Commandments, he will be inclined to safeguard the rights of his patrons. But he will hold to either one ethical opinion or the other. It is not so much a matter of law as it is of his previously acquired ethical philosophy.

So also, students of mental health and mental disorders approach the task of studying their data with definite conceptions of man's constitution, the nature and origin of the mind, and the nature of mental and emotional activities. These questions are not actually psychiatric or hygienic problems, but philosophical in nature; but every psychiatrist, hygienist, or psychologist who speaks or writes takes an implicit or explicit stand on these and similar matters. For example, Dr. X., a psychiatrist, holds that there is no such thing as an immaterial mind. Mr. Y., a psychologist, maintains that there is. Miss Z., a hygienist, doesn't know exactly, but follows the behaviorist school of thought. Dr. X. and Mr. Y. have explicit but contradictory opinions.

Miss Z. implicitly holds with Dr. X., but they all have a more or less fixed opinion about the philosophical question: "Has man an immaterial mind or not?"

CONTEMPORARY PHILOSOPHY QUITE UNSTABLE

Contemporary philosophy has contributed not a little to mental confusion and instability. An adequate philosophy of life is essential for psychic poise. The mind rests in truth alone and refuses to accept any camouflage or make-believe as a substitute. Any philosophical opinion denying man's ability to attain truth, goodness, and happiness is bound to have tremendous psychic repercussions. Probably never before in the history of the human race has as great a philosophical confusion prevailed as exists today.

Many who call themselves philosophers deny that man has a soul. The endocrines take the place that from time immemorial was held by the soul in dualistic psychology. As an obvious consequence soul, mind, and will are denied with all the practical implications of such denial. Man is robbed by modern philosophy of even the abstract possibility of attaining the truth and the goodness which alone can satisfy him.

Psychological determinism has definitely taken over the place of free will. Man, who thought he was free, finds himself forced by the principles of modern thought to accept a particular mode of activity. His consciousness, his awareness of his freedom to make a choice, is, he is told, merely a snare and a delusion. Thus the man of modern philosophy is determined by heredity, by environment, and by the present motive.

Man is further informed that lacking a soul, he has no ultimate goal to seek. He is, however, encouraged to "keep going," to "keep in motion," to "choose activity which leads to further activity," until he returns to the earth whence he sprang "by spontaneous generation!" The natural law by which men know essential right and wrong is to be scoffed at. There is no power left to men by which they may share in the light of the eternal law.

Even God's very existence is denied. Society today under the guise of a nationalistic state has deposed God, ascended His throne, and requires man and his conscience to bow before it.

Christ is now frequently considered at best an able psychologist or an astute political leader. He was wedged in by an eminent professor in a recent lecture between Socrates and Plato as the second ablest man

of all times. His Godhead is only too often totally forgotten and denied.

The hereafter, heaven or hell or the possibility of revelation to give us knowledge of such realities, is rejected with becoming "scientific broad-mindedness." Though there is much talk of socializing man and preparing him for his work in society, his social instinct is ignored and his seemingly instinctive social tendencies are attributed to a variety of causes, environment, conditioning, or decreased resistance at the synapse. So the individual is left adrift in mid-ocean without a rudder or a compass, and is bound for nowhere. This is how matters stand when materialism, naturalism, or "science" is applied to man.

The sad fact is that materialism, naturalism, and science are totally inadequate because man has in him a vital principle which is spiritual and immortal and which seeks happiness. Materialism, naturalism, and "science" have produced blinding confusion, and have denied in man every element essential to his intellectual, moral, social, and psychic stability and integrity. Psychic balance, which should be anchored on the immutable rock of truth, is today shattered. Truth is denied and men are given no valid reason for their existence, why it is better to be than not to be. We may well sympathize, then, with people when they tell us of their confusion; and yet, man's mind seeks truth, his will seeks good, and the entire man seeks a goal, all of which are denied by modern thought. Modern philosophy has contributed much to instability, mental disease, and psychoses.

The philosophy of man prevalent in contemporary psychiatry is that of materialism. Among dozens of false judgments that abound in such a philosophy, the following stand out boldly against the horizon:

1. Experiment is the only way — the Royal Road — to knowledge.
2. As God cannot be seen, weighed, or measured in a test tube or experimentally, His existence cannot be scientifically established. At most, agnosticism can be reached on the crucial question of God's existence. Revelation is impossible.
3. Not only can the supernatural not be known, but man is totally incapable of arriving at knowledge of the spiritual or suprasensuous.
4. Metaphysics is of utterly no avail and is unable to justify its claims.
5. There is no basic difference between life and nonlife. This is well explained by Patrick:

Mechanism stresses the purely mechanical character of all processes, organic as well as inorganic. In explaining life, whether of micro-or-

ganisms, plants, animals, or man, it is necessary to assume no other materials and no other forces than those exhibited in inorganic nature, as, for instance, in the movement of the spheres or the formation of rocks and soils or of chemical compounds. Physical and chemical laws are sufficient to account for all forms of life and perhaps even of mind. They can all be described in terms of matter and motion. They are all, in the last analysis, movements of mass particles in space. The so-called higher forms are distinguished by greater complexity of structure, but they involve no new materials and no new forces. The human body with its marvelous brain and nervous system, as well as the whole kingdom of plants and animals, can be analyzed into the same carbon, oxygen, hydrogen, nitrogen, calcium, and other chemical elements, as the soil, the rocks, and the water. Nor are any other forces at work in them than are present in the inorganic bodies. "A living organism is a complex system of physical-chemical mechanisms." Continuity prevails in nature from the simplest to the most complex forms.⁴

6. Man has no soul.

It is not necessary . . . to assume any mysterious vital force to account for life. . . . Life is the outcome of the organization of non-living elements. Living bodies are highly organized, highly complex forms of simple inorganic elements. A living body contains no mysterious entity called a vital principle, or vegetative or sensitive soul. It is not a soul or vital spark in living organisms which causes life, or gives rise to the power of growth and reproduction.⁵

7. There is no purpose to life.

. . . nor is it necessary to suppose that evolution is purposive or teleological. We should not gratuitously import into the processes of nature any mental concepts, or spiritual or psychic forces, or any notions of ends, purposes, or values.⁶

It would not be consistent with the mechanistic conception to think of the world of organisms as an unfolding of something wrapped up or potentially present in the original matter of energy; neither would it be consistent to think of it as working progressively either consciously or unconsciously toward any end, purpose or goal.⁷

8. An immaterial or spiritual faculty of thought does not exist.

9. Thought is a function of the cerebral cortex or the brain.⁸

10. The only type of knowledge that exists is sense knowledge. All knowledge is extended. There is no such reality as an idea or in-extended knowledge.

11. The will is not free.

The truth is that you have an illusion of a psychic freedom within you which you do not want to give up. I regret to say that on this point I find myself in sharpest opposition to your views.⁹

I have already taken the liberty of pointing out to you that there is within you a deeply rooted belief in psychic freedom and choice, that this belief is quite unscientific, and that it must give ground before the claims of a determinism which governs even mental life.¹⁰

12. Mental normalcy as well as abnormalcy is an organic phenomenon.

13. All the mental faculties as well as bodily characteristics of a human being are inherited. These qualities, of course, are conditioned by subsequent environment.

Thus under the sway of materialism is witnessed the denial of God, of the supernatural, of His kindly paternal providence; of the soul, its spirituality and immortality; of the mind, its object and activities; of the will, its freedom and urge toward infinite goodness.

It is utterly impossible to build a solid system of psychiatry on these denials. A more sturdy foundation is needed. We must look elsewhere.

PLAN OF BOOK

We hope in the following chapters to present a less "scientific" but more complete and satisfying viewpoint in psychiatry. We will present the dualistic mind-body concept which alone can explain the complete man. In approaching this discussion we have divided our material as follows:

Part I outlines the problem and describes the normal personality toward the development of which all psychotherapy strives.

Part II describes the concept of the psychogenesis of mental and emotional disorders and outlines the intellectual, emotional, and volitional disturbances concerned in their etiology. Other important etiological factors such as heredity, habits, and the unconscious are discussed in this section.

Part III begins the clinical approach to psychiatric disorders. In this section are discussed the methods of examination of the mentally ill patient.

Part IV is devoted to a description of etiology, clinical manifestations, and treatment of the psychoneuroses.

Part V is devoted to the etiology, description, and therapy of the psychoses.

Part VI describes certain conditions such as epilepsy, the psychopathic personality, mental deficiency, and sexual disorders which have very definite relations in other fields of study, particularly in neurology, education, and sociology.

Part VII summarizes our ideas concerning Psychiatry, Philosophy, and Religion.

The *Glossary* at the conclusion of the book (p. 607) is intended for ease of reference; most of the important technical terms used in the text will be found there.

FOOTNOTES

1. John S. Bonnell, *Pastoral Psychiatry* (New York: Harper and Brothers, 1938), p. xi.
2. Gen. 3:19.
3. Dan. 2:1-49.
4. George Thomas White Patrick, *Introduction to Philosophy* (Boston: Houghton Mifflin Co., 1924), p. 79.
5. *Ibid.*, p. 94.
6. *Ibid.*, p. 79.
7. *Ibid.*, p. 84.
8. Consult the chapter in this text on *Schizophrenia*. Also consult Roland Dalbiez, *Psychoanalytical Method and the Doctrine of Freud* (London and New York: Longmans, Green & Co., 1941), II, 234 ff.
9. Sigmund Freud, *A General Introduction to Psychoanalysis* (New York: Liveright Publishing Corp., 1935), p. 45.
10. *Ibid.*, p. 95.

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THE EXTENT OF MENTAL DISORDERS

It is estimated that over 1,350,000 individuals occupied beds during 1955 in the approximately 1114 private and public institutions which are for the psychotic, the epileptic, and the feeble-minded. The number of patients in hospitals for the mentally ill is equal to the number of those in all other types of hospitals. In normal times, there are more mental patients in public institutions of the country than there are full-time students in its colleges and universities.

It is obvious that the institutional population does not account for all the mentally ill. Not even all psychotic patients are in hospitals. Because of inadequate facilities for the care of this type of patient, laxity of standards born of ignorance, prejudice, and a serious cultural lag, only those mental patients who become violent, dangerous, or gravely antisocial, enter institutions. No accurate estimate can be made as to how many psychotic individuals are not hospitalized. It has been estimated that not more than four fifths of the psychotic patients are receiving proper care. Cobb¹ estimated that there are between 600,000 and 2,500,000 persons at large in this country who suffer from mental disorders so severe that they could be legally institutionalized. Although there are no reliable statistics, such estimates by reputable authorities make it clear that many people who need psychiatric attention are not receiving it.

Besides this large group of seriously ill, there is a vast unnumbered body of neurotic individuals and psychopathic personalities. It is difficult to comprehend the enormous extent of these disorders. Sadler² is of the opinion that almost one half of the entire adult population of the United States is neurotic to a greater or lesser degree. Some idea of the magnitude of the problem may be obtained from the knowledge that about 45 per cent of those discharged from the military services for physical disability during World War II were released for psychiatric reasons. On December 31, 1945, 12,275 patients from World War II were receiving psychiatric care in Veterans' Administration hospitals. This constituted 43 per cent of all World War II veterans receiving Veterans' Administration care. During 1956 it is

estimated that approximately 2,500,000 persons, including men, women, and children, were treated by psychiatrists. In one study it was estimated that 61 out of every 1000 persons have a mental or personality disorder;³ another study tended to give validity to this figure by finding that 69 out of every 1000 persons had a mental or personality disorder.⁴

In 1956 there was a slight decrease in the number of patients residing in mental hospitals. This decrease was 7234 patients. In New York State, for example, an analysis of the 1955-1956 census of its mental hospitals showed a decrease of 500 patients instead of an expected increase of 2500. This decrease was attributed to the large-scale use of chlorpromazin and reserprin. In a 12-month period, 30,000 patients received these drugs. Whether this decrease continues remains for the future to determine.

From the few available statistics, there is little doubt that the incidence of serious mental disorders is increasing. Many psychiatrists believe that the increase is only apparent because the profession has become more alert to the presence of these disorders. To a large extent, this may be due to greater life expectancy, since the greatest increase in mental disorders is in the age group over 40. From 1912 to 1936, the rate of incidence of arteriosclerotic psychoses for the population (age 40 and over) increased from 7.7 to 49 per hundred thousand, an increase of 636 per cent. H. M. Pollock, New York Department of Mental Hygiene, according to Overholser, has made estimates of expectancy of admission to a mental hospital based on figures for 1920, 1930, and 1940. For age 20, he gives the following expected rates per thousand:⁵

	<i>Male</i>	<i>Female</i>
1920.....	55.2	54.1
1930.....	69.0	59.4
1940.....	83.1	84.0

These figures from data from the National Institutes of Health and the Veterans Administration support the opinion that serious mental illness is increasing:

In 1931 there were 106,000 first admissions to mental hospitals.

In 1951 there were 171,000 first admissions.

This represents an increase of 62 per cent in 20 years. The rate per 100,000 in 1931 was 85; in 1951 it was 111. This is an increase of 30 per cent. In 1931 there was a total mental hospital population of

374,000; in 1951 it was 590,000. This is an increase of 58 per cent. The number of patients in mental hospitals was 301 per 100,000 population in 1931. In 1951 this had increased to 382 per 100,000; an increase of 27 per cent. In one year only, 1943, was there a decrease in admissions. In that year there was a decrease of 0.3 per cent. Of 171,000 first admissions to mental hospitals, 56 per cent were males and 44 per cent were females.

The figures for 1955-1956 continue to reflect this increase:⁶

<i>Item</i>	<i>1955</i>	<i>1956</i>	<i>Percentage Increase</i>
First admissions.....	122,394	126,510	3.4
Readmissions.....	55,626	59,521	7.0
Discharges.....	119,146	134,702	13.1
Deaths in hospital.....	44,400	48,478	9.2
Resident patients at end of year.....	559,281	552,186	-1.3
Personnel employed full time at end of year.....	145,462	152,439	4.8
Maintenance expenditures:			
Total.....	\$618,229,797	\$662,146,372	7.1
Per patient.....	\$1,112.84	\$1,190.32	7.0

According to the National Committee Against Mental Illness, a mental patient spends an average of 8 years in a state hospital. The cost per patient averaged \$3.26 a day, or \$1,190 a year. This would represent a cost to the states of \$7,047,000,000 (for eight-year stay). If these patients were able to work during this time, they would have earned over \$27,000,000,000 in wages. They would have paid \$453,000,000 per year in income tax, a total of over 3.6 billion dollars for the eight-year period.

THE PROPHYLAXIS OF MENTAL DISEASE

The greatest satisfaction derived from the study of mental disorders is the knowledge that many of them are preventable. The Italian criminologist, Lombroso, in vain attempted to establish the existence of the "born criminal." He maintained that some people were born with biological drives that would inevitably lead to criminal careers. This theory has long since been disproved. Some individuals are, unfortunately, born with biological handicaps that prevent normal growth and development of the body and the mind. Happily, however, the greater portion of mental problems arise as a result of postnatal

environmental influences. Such disorders are obviously not congenital or inherited, but acquired.

CASE 1: *Psychosis Due to Congenital Defect*

L. W., from the very beginning of her development, manifested abnormal traits. She demonstrated severe infantile tantrums, frequently tore the bedclothes and her apparel, refused to eat on many occasions, and failed to speak at the proper age. Her failure to speak and other characteristics gave rise to the belief that she was a deaf-mute and she was accordingly sent, at an early age, to an institution for the care of such patients. Soon thereafter, it was discovered that she was not deaf, but was suffering from an aphasia due to a cerebral defect. Long years of training produced some ability to speak and to perform certain simple tasks. At the time of puberty she displayed definite psychotic symptoms which necessitated institutional care.

The vast majority of mental illnesses is due not to congenitally acquired or hereditary defects as in the case above, but is due to factors over which it is possible to exert a large degree of control. The following types of psychiatric disorders are subject to control, if proper preventive measures are adopted:

1. Disorders due to syphilis,
2. Disorders due to alcohol,
3. Disorders of psychogenic origin, including both psychoses and neuroses,
4. Psychoses due to drugs,
5. Psychoses with pellagra.

Mental deficiency, although usually regarded as a rather hopeless condition, can hardly be prevented, but with the right kind of training much improvement can be expected. Many intellectually inferior individuals can be trained to earn their own living and to conduct their own affairs with a satisfactory degree of prudence. The work of Bernstein⁷ with his morons and high-grade feeble-minded children at the State School for Feeble-minded at Rome, New York, has opened up tremendous possibilities in this field.

It is obvious that discussion of the prevention of many of the mental disorders listed above is outside the scope of psychiatry. It is in the prevention of the psychogenic mental disorders that the psychiatrist, through the Mental Hygiene Program, hopes to play a part. Although writers differ widely in their concepts of the origin and nature of mental disorders, most of them, except perhaps a few logical material-

ists and strict organicists, agree that a high percentage of mental disorder is psychogenic in origin and is consequently preventable, if undesirable situations can be avoided, their recurrence eliminated, or their depressing results realistically encountered. Most cases of mental disorder, including many of the psychoses, are the result primarily of unhealthy mental and emotional habits which proper home and school training could have prevented.

In this sense, most psychiatrists consider the majority of the psychoses as functional. As will be seen, they are not often too clear in their explanation of the term "functional," but by the use of the term it becomes apparent that they do not postulate an organic pathology. These disorders are not due to disease of the soma, although such a disturbance may be associated with it. They are, primarily, disturbances of the psyche which result in faulty methods of thinking and willing. As such, the process may not be reversible, but could probably have been prevented. Schizophrenia, manic-depressive psychoses, paranoid conditions, paranoia, the psychoneuroses, and most personality disorders are psychological not only in nature, but also in origin.

THE MENTAL HYGIENE PROGRAM

Although the number of patients discharged from mental hospitals has increased in recent years, it is apparent that our main hope in lowering the incidence of mental disorders lies in the field of prevention. All concerned with the matter are becoming more convinced that prevention is largely a matter of education in a wide sense. This education is a composite task to be accomplished by the home, the school, the church, and the medical profession working hand in hand. Excellent progress in the co-ordination of this work is being made by the National Association for Mental Health, Inc., which has its offices at 10 Columbus Circle, New York, New York. It is obviously impossible to indicate exactly the extent to which mental disorder is preventable, but after carefully weighing the opinions of those who have a right to express them, we would perhaps not be greatly in error in saying that about 50 per cent of the serious mental diseases could be prevented by the application of existing knowledge. If this is true, it would seem quite safe to assume that a large number of minor mental maladjustments can also be prevented by appropriate education in mental hygiene.

The value of a sound mental hygiene program has been abundantly established. It has long since passed beyond the experimental stage.

The psychological redemption of unborn millions and the preservation of the mental health of our children is no mere nebulous promise. However, a complete description of the achievements of the Mental Hygiene Program is not within the scope of this book.

The first child guidance clinic was established in this country only a quarter of a century ago. At the present time, most of the large cities in the United States employ such clinics as an integral part of the school system. They vary considerably from place to place in form, but have in common the fact that they are predicated on the twofold assumption that the foundations of psychotic and neurotic disorders are laid in childhood, and that they are essentially controllable disturbances of personality. As indicated above, the Mental Hygiene Program came into its own when World War II brought to light the very great incidence of psychiatric disorders in the population. The value of the psychiatrist in the Army and Navy was demonstrated not only in the treatment of mental disorders, but also as personnel officers, morale builders, and psychological consultants.

It is becoming increasingly recognized that mental hygiene and psychological counsel can do much to prevent the hundreds of thousands of divorces that occur annually. Some knowledge of the great social possibilities of this phase of the hygiene movement can be obtained by studying the achievements of the Family Life Bureau of the National Catholic Welfare Conference, 1312 Massachusetts Avenue N.W., Washington, D. C.; the Institute of Family Relations, 607 South Hill, Los Angeles, California; the Marriage and Family Life Institute of Detroit, and similar organizations.

SUMMARY

In approaching the important study of the problems of mental health, the student should realize:

1. The enormous extent of the problem,
2. That the problems of mental health can, with difficulty, be remedied once the disorder is acquired,
3. That the chief hope of psychiatry lies in the field of prevention,
4. That, for the most part, the prevention of mental disorders is a problem of education, rather than of the medical profession,
5. That the prevention of mental ill-health and the development of sound personality are two of the greatest tasks of the future and constitute a major challenge to civilization.

FOOTNOTES

1. Stanley Cobb, *Borderlands of Psychiatry* (Cambridge, Mass.: Harvard University Press, 1944), p. 47.
2. William S. Sadler, *Theory and Practice of Psychiatry* (St. Louis: The C. V. Mosby Co., 1936), pp. 149-150.
3. Based on a study in Baltimore, Eastern Health District, in 1936 (Lemkau, Tietze, and Cooper), *Modern Medicine*, Vol. 84, July 15, 1956, 84.
4. Based on a study in Williamson County, Tennessee, in 1938 (Roth and Luton), *Modern Medicine*, *ibid.*
5. Winfred Overholser, *Mental Hygiene: Classification and Statistics of Mental Disease* (Washington, D. C.: Postgraduate Courses, George Washington University, 1946), II, pp. 75-78.
6. U. S. Department of Health, Education and Welfare, Public Health Service. Public Health Reports, Reprint No. 3286, Vol. 72, No. 1 (January, 1957), pp. 14-15, "Mental Patient Data for Fiscal Year 1956."
7. C. Bernstein, *Social Care of the Mentally Deficient*, pamphlet (Washington, D. C.: National Catholic Welfare Conference, 1930).

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MENTAL HEALTH AND THE NORMAL PERSONALITY

Before beginning a study of mental abnormality, it is extremely important to establish some criterion as to what constitutes a normal personality. The average layman, when asked to describe his concept of a normal person, is inclined to answer in terms of "average"; that is, he would consider those people normal who are more or less like average people. There is, however, no generally accepted concept of what constitutes normalcy.

For many years, the socioeconomic definition of normalcy was generally accepted. In this definition, the average person was said to possess ordinary and sound emotional, mental, and volitional life; some individual differences and peculiarities which might even manifest themselves in an occasional neurotic episode; social and economic competency, or if there were any social or economic defects, they were due to other factors than mental. Social and economic competency implied that the person possessed the actual ability to be economically independent; he was able to support dependents; he was able to maintain a sufficiently satisfactory status as a member of the group.

Although for many years employed as the ordinary and primary test of mental normalcy, the socioeconomic criterion of mental health is a legal and sociological definition, and not acceptable from the psychiatric standpoint. For example, a man in a desert with no dependents could remain normal or become psychotic. Mental disorders are primarily personal, not social. There are two other limitations to the use of this criterion. First, many people are socially and economically inadequate for reasons other than mental. Second, many people are socially and economically adequate, at least to such an extent that they are not burdens to the community, and still cannot be considered normal, for example, hysterical or scrupulous persons, and certain types of high-class morons.

It is obvious, therefore, that some other criterion than social and economic competency is necessary for a psychiatric concept of normalcy. James C. Moloney¹ concluded that "No two authorities agree

on a generally acceptable criterion of mental health." Eaton² in discussing this subject states: "It is clear that the lack of definition of mental health is related to relativities inherent in human nature. Man and his conditions of living are found under many varying conditions, which defy neat and logical classification. At the present state of science, we know of no effective method of satisfactorily overcoming the previously mentioned limitations."

MENTAL HEALTH

Before mental health can be promoted, one should be as well informed as possible concerning this subject. Unfortunately, this is not easy. Mental health is an elusive concept. For instance, Eaton, writing in the *Journal* of the American Psychiatric Association, stated: "Mental health as a scientific concept does not now exist."³

With Eaton's comment as a preliminary warning, we must consider some of the attempts which have been made to define mental health.

It must be clear from the first that mental health is not the same as mental hygiene. *Mental hygiene* is concerned with the maintenance of mental health and the prevention of mental disorders. *Webster's Dictionary* defines mental hygiene as "the science and art of maintaining mental health and preventing the development of insanity and neuroses." Mental hygiene clinics have been established rather extensively in schools, in hospitals, and in health centers. Although these clinics were primarily concerned with prevention, they soon, of necessity, became treatment clinics because the need for therapy was so great. The number of those demanding treatment far outweighs those seeking preventive advice. Unfortunately, there are not many parents who have the foresight to seek a positive development of mental health in their children. Until such insight is gained, the teacher is the one most strategically situated in the educational system to contribute to the maintenance of the mental health of the child.

Difficult as the task may be, let us attempt to understand and define mental health. Health is defined by *Webster's Dictionary* as "a state of being hale, sound or whole in body, mind or soul; well-being; especially a state of being free of physical disease or pain." Healthy-minded is defined as "having a wholesome outlook on life." Wholesome is "that which is good for one, whether physically or morally." Webster thus defines mental health in terms of the obvious. Hadfield does the same thing in different words: "Mental health is the full and harmonious functioning of the whole personality."⁴

Mental health has been defined in other frames of reference. For example, Erich Fromm defines mental health in terms of social function:

The term normal or healthy can be defined in two ways. Firstly, from the standpoint of functioning society one can call a person normal or healthy if he is able to fulfill the social role he is to take in that given society—if he is able to participate in the production of society. Secondly, from the standpoint of the individual, we look upon health or normalcy as the optimum of growth and happiness of the individual.⁵

Rennie and Woodward equate mental health with individual “maturity”:

In very simple terms, a mature and mentally healthy person is one who: 1. Respects and has confidence in himself, and because he knows his true worth, wastes no time proving it to himself and others; 2. Accepts, works with, and to a large extent enjoys other people; and 3. Carries on his work, play, and his family and social life with confidence and enthusiasm and with a minimum of conflict, fear and hostility.⁶

Happiness is emphasized by Karl Menninger:

Let us define mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. Not just efficiency, or just contentment—or the grace of obeying the rules of the game cheerfully. It is all of these together. It is the ability to maintain an even temper, an alert intelligence, socially considerate behavior, and a happy disposition. This, I think, is a healthy mind.⁷

Preston also defines mental health in terms of social adjustment:

Mental health consists of the ability to live: 1. within the limits imposed by bodily equipment; 2. with other human beings; 3. happily; 4. productively; 5. without being a nuisance.⁸

Other definitions are equally unsatisfactory. For example, the definition of health of the World Health Organization is a statement of the obvious:

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.⁹

The Expert Committee on Mental Health of the World Health Organization produced a better but still unsatisfactory definition of mental health and mental hygiene:

The Committee recognized the necessity for explaining as precisely as possible what is meant by the terms "mental health" and "mental hygiene." Mental health was defined as a condition, subject to fluctuations due to biological and social factors, which enables the individual to achieve a satisfactory synthesis of his own potentially conflicting, instinctive drives; to form and maintain harmonious relations with others; and to participate in constructive changes in his social and physical environment. Mental hygiene was interpreted as referring to all the activities and techniques which encourage and maintain mental health.¹⁰

It is interesting to note that none of these definitions make any mention of supernatural motivation or of man's striving for an ultimate goal, although Hadfield does mention the need for "completeness," which, if interpreted properly, would certainly include man's need for a Supreme Being. It should be emphasized that moral goodness does not, of itself, bring mental health. A man of impeccable morality may be mentally unhealthy. A good life does not protect against neurotic disorders. On the contrary, one cannot be immoral and be mentally healthy. Neither can he be asocial and mentally healthy. Mental health cannot be complete unless man is properly oriented toward his ultimate goal. May the authors suggest the following definition of mental health?

Mental health is that state of well-being in which there is a dynamic, efficient functioning of the whole man which brings about co-ordination of his powers in such a way as to develop most perfectly his psychic potentialities for the purpose of achieving his goals, both present and remote.

A brief explanation of the terms of this definition may be helpful:

1. *State of well-being*—We often speak of the "glow of health" which accompanies a state of physical well-being. A state of mental well-being would also be expected to accompany mental health. This was referred to by Bishop Sheen as "peace of soul." If we are at peace with God and the world, we would certainly have a sense of well-being, but before this feeling is complete, we must also be at peace with ourselves.

2. *Dynamic*—Mental health occurs in a living body, vibrant and active. It is not static; it changes from time to time. What is mentally healthy at one time might be evidence of abnormality at another.

3. *Efficient*—The best interests of the individual must be served with the least amount of wasted motion.

4. *Whole man*—The human composite is made up of body and soul which together form the unit man. Man is neither body nor soul, but a combination of both. Mental health, therefore, is of the whole man and not primarily referable to either body or soul.

5. *Co-ordination of his powers*—Man is an extremely complex being composed of a body and a soul. He has external cognitive powers, internal cognitive powers of the sensory order, as well as intellect. The intellect gives rise to ideas, judges, and reasons. Man possesses one will or appetitive power with two tendencies: a sense urge which follows pleasure and is not free and a rational urge which is free to choose or not to choose. The will depends upon intellectual appreciation of the object as upon a motive or impelling force for its own activity. If each power of man acted without interference of other powers and under the guidance of reason, he would enjoy great peace and ease. Such was the case before the sin of Adam and Eve. Now man daily experiences difficulty in following reason because it is austere, speaks an abstract language, and recommends deferred pleasures.

Although there is no generally accepted concept of what constitutes mental health, it has certain characteristics which are fundamental:

1. It is dynamic. Mental health is not static. It is likely to fluctuate with changes in the milieu.

2. It concerns the function of the whole organism because mental and physical health form a continuum. They cannot be separated one from the other because of the natural union of body and soul in man. Disturbances of mental health cause repercussion in the physical and vice versa.

3. Mental health is not the same for all people. It will vary in degree.

4. Mental health is more than an absence of symptoms.

5. Physical heredity plays no part in mental illness. Social heredity is important. This follows from the fact that mental illness is an acquired trait and that acquired traits are not transmitted by physical heredity.

6. In mental health, activity must be goal-directed, whether this goal be an immediate ambition or toward the supernatural.

CLINICAL DEFINITION OF NORMALITY

For practical clinical purposes the following definition of normality published by Dr. Edward Glover of London is useful. Eaton would classify this under his "Ideal Type" personality description. Glover

defined the *normal person as being free of symptoms, unhampered by mental conflict, able to maintain a satisfactory working capacity, and able to love someone other than himself*.¹¹ This is an excellent short description of the normal personality. In addition to the above, the normal personality should also include:

1. *Orientation toward future goals, that is, an average regard or concern for the future.* Mentally ill people are characteristically defective in this regard, e.g., psychopathic husbands who make insufficient provisions for the family future, and hysterical patients who live only for their present gratification.

2. *Reasonable satisfaction from daily activities.* Average people ordinarily derive a certain satisfaction from daily life. Abnormal people are typically unhappy and there is generally no sufficient reason that adequately explains or justifies their unhappiness.

3. *Exterior conduct, substantially conforming to the standards of the group.*

4. *The ability to recognize and correct mistaken ideas and attitudes.* All people make mistakes and entertain false beliefs, at least for a time, but normal individuals can be brought to understand the falsity of their position. This is frequently not so in the abnormal; for example, the paranoiac who believes himself the victim of a sinister plot, and the neurasthenic individual who believes himself the victim of strangely contradictory and incurable pains, can hardly be dissuaded from his false ideas.

5. *A well-balanced emotional life.* Practically all people have occasional emotional upsets or suffer from various types of emotional strain, but the abnormal individual is pathologically and almost continuously influenced by his emotions.

6. *The ability to adjust oneself to environmental changes.*

The normal person may thus be defined as one who conforms to the average human being in his methods of thinking, feeling, and acting, is reasonably happy, emotionally balanced, and adjusted and oriented toward future goals. On the contrary, the abnormal person is one who, for a more or less prolonged period of time, to a greater or lesser degree, deviates from the average human being in ways of thinking, feeling, and acting, is unreasonably unhappy, emotionally unstable and unadjustable, and poorly oriented toward future goals. There is no clearly fixed or well-defined line between mental normalcy and ab-

normalcy, and, in many instances, prolonged study is necessary to make the distinction.

Many people who have found a place in the hall of fame have shown abnormalities: for example, De Quincey was a drug addict; Schopenhauer is said to have been extremely irascible and delusional; Voltaire was a hypochondriac. Peculiarities of some kind or another are not uncommon in otherwise normal individuals. Although these unusual characteristics may produce an eccentric type of personality, a complete personality inventory is necessary before they can be regarded as evidences of mental abnormality. The maladjustments of normal people differ from those of the mentally ill, either in duration or degree of departure from the average performance. Case studies give convincing proof that mental abnormality is frequently an exaggeration of a normal process. For example, the person who has developed into a schizophrenic demonstrates excessive indulgence in introversion and fantasy. Properly and moderately used, both of these processes are not only good, but necessary; the schizophrenic, however, uses them habitually to excess. Most of us have an inherent urge to put on others the blame for the mistakes which we ourselves have made. Paranoid individuals do this to excess. Their entire lives are likely to be predicated on the habitual projection of their failures. In the face of difficult problems, it is natural to feel tempted to evade them. Conversion hysteria is the ultimate degree of such evasion. It might be said that the mentally ill are just like ourselves, only more so.

The above is also the conclusion reached by outstanding psychiatrists and psychologists. A few references from their writings will emphasize the quantitative differences between normal individuals and psychotics.

Fromm-Reichmann maintains that the difference between normal individuals and psychotics is one of degree and not of kind. She states:

Further justification for my not discriminating between the use of experiences gained in the treatment of the more serious mental disorders of the psychotic and those of the milder forms of problems in living of the neurotic stems from another conviction. It is my belief that the problems and emotional difficulties of mental patients, neurotics or psychotics, are, in principle, rather similar to one another and also to the emotional difficulties in living from which we all suffer at times. Should these difficulties become so great that a person is unable to resolve them without help, thereby feeling the need for assistance, he may become a mental patient in need of psychotherapy.

I have put this statement at the beginning of this book because of my

firm belief that the first prerequisite for successful psychotherapy is the respect that the psychiatrist must extend to the mental patient. Such respect can be valid only if the psychiatrist realizes that his patient's difficulties in living are not too different from his own. This statement is not just a humanitarian or charitable hypothesis but a *scientific conviction*. There are various well-known psychiatric facts which point in this direction.¹²

Preston also contends that the normal and abnormal do not differ qualitatively but quantitatively. He writes:

In the following chapters I hope that you will find references to me, to yourself, and to your friends. This does not mean that we are all mentally sick. All that it means is that the mentally sick are *people much like you and me*, using the same mechanisms that you and I use, but using them more rigidly and less appropriately.¹³

Mercier likewise maintains that normals and abnormals differ in degree and not in kind. He states:

Between these pathological states and the healthy ideal state to which we have opposed it, there are possible an almost infinite variety of intermediary states.¹⁴

Klein, discussing the nature of mental hygiene, while differentiating health from disease discusses the problem of the normal man and of the abnormal. He inquires whether it is "just a matter of degree" that segregates the normal from the abnormal or whether it is something "discontinuous and qualitative rather than continuous and quantitative." He observes:

As has already been suggested, the popular view is to dispose of the problem by means of a normal-abnormal dichotomy as contrasted with what many psychologists regard as the more "scientific" distribution curve approach. For these psychologists the abnormal is just an extreme form of the normal. There is no difference in kind; there is only a difference in amount, like the difference between a small and large loaf of bread. According to this conception the abnormal is merely an exaggeration or quantitative distortion of the normal.¹⁵

Lastly we quote White, who remarks:

Abnormal personalities are not mysteriously set apart from the normal. Their various peculiarities represent exaggerations of what is to be found in every human being. They are therefore well suited to enlarge our understanding of the whole process of personal adjustment.

If we know what can go wrong in human development, we are the wiser in making it go right.¹⁶

From the above references, it is evident that outstanding authorities maintain that abnormal mental conditions are merely exaggerations of the normal, are quantitative and not qualitative deviations.

THE ABNORMAL PERSONALITY

Although the study of psychiatry is frequently neglected by those in the practice of medicine, there is little doubt in the minds of such practitioners of the need for such study. In the not too remote past, many medical men bragged about their lack of knowledge of mental diseases. As pointed out elsewhere, almost every patient seen by a practitioner of medicine has an emotional element in his illness, whether this constitutes the whole malady or is merely an obligato to some more serious ailment. Entirely apart from his professional interest, the physician, as well as all other professionals who must deal with emotional problems, should have, from a personal, selfish point of view, an excellent motive for a detailed study of mentally ill people. Such a study is of the utmost help toward the proper development of one's own personality. By a study of the causes and development of mental maladjustments, one can gain a clear insight into the evil consequences of forming bad intellectual, emotional, and volitional habits. They may thus, instead of learning the hard way, profit by the mistakes of others and learn in a vivid and unforgettable manner the extreme importance of habits of self-control and the utilization of healthy mental and emotional mechanisms.

Much inefficiency, cruelty, misunderstanding, and pain can be voided by a proper understanding of mental illness. As indicated above, the number of such individuals is legion. Their number is so great, and our daily contacts with them so frequent, that we could be said to have a social obligation to understand them.

A knowledge of personality development is especially important for parents, since the early development of character and mental and emotional habits is the result of parental influence and family environment. Parents, above all, should be armed with the important information supplied by the studies of mental hygiene and psychiatry. The teacher, who wields such power in the formation of the child, should not only be personally well balanced, but should also be well informed and capable of directing the emotional development of the youthful charges entrusted to him. The following case illustrates the important part

played by parent and teacher and how necessary is their full and entire co-operation.

CASE 2: *Neurotic Trends in a School Child*

Jean, a girl of ten years, entered a private school after having spent three years in what was described as an "ultraprogressive school." She was highly emotional and excitable and it was hoped that the quiet and discipline of the new school might benefit her. Jean was striking in appearance, intelligent, and charming, but somewhat artificial in her behavior and conversation. She was well liked by the other children. She was, however, frequently overheard telling them exaggerated tales which were so absurd that, young as they were, the children questioned their truth. The children soon lost interest in the tall tales, and, after a few abortive attempts to retain their interest by making her tales more fantastic, Jean was forced to lessen the number of her stories for lack of an audience.

A slight accident on the playground, on one occasion, resulted in a markedly exaggerated injury to her ankle. Another slight injury caused her to carry her arm in a sling for many days, and a pain in her knees, for which no physical cause could be found, resulted in a severe limp which persisted for weeks. When called upon to recite, Jean frequently fainted.

In the middle of the school term, a motion picture was shown in which the father was killed in an accident. Jean began to sob audibly and had to be removed from the theater. She wept in an uncontrollable manner for some time, giving as the reason, that her father had died in just the same manner as was shown in the picture. It was known to the school authorities that, although her parents were separated, her father, very much alive, was in another city. Although this fact was pointed out to her, she could not be persuaded to change the story.

In an effort to solve the problem, it was decided that Jean's mother would ignore her complaints, spend more time with her, and keep her away from the movies and other activities of an exciting nature. On the part of the school, help was unconsciously given by the other children who, by their companionship and example gradually set her straight. A frank discussion between Jean and her teacher was quite effective, and although Jean still has an occasional lapse into her neurotic tendencies, the combined effort of home and school is gradually effecting a cure which, it is hoped, will be permanent.

An understanding of emotionally disturbed people can only be obtained by studying them. Theology and philosophy are excellent

studies, but an understanding of the nature of God, the mysteries of religion and other theological metaphysics, the knowledge of being, act, and potency, the syllogism, even the study of abstract rational psychology leaves one completely ignorant of the technical art of helping people with emotional disturbances. Even the study of somatic medicine, especially as it is so frequently taught in our medical schools, is no guarantee of the knowledge of how to handle the psychic ills of humanity.

The same holds true *a fortiori* for the study of law, engineering, and other scholastic and technical disciplines; but the study of theology, philosophy, and somatic medicine have been singled out because of the prevalence of the mistaken belief that these branches of knowledge automatically equip the student with a knowledge of the technique of helping the psychiatrically ill. Many seminaries, schools of divinity, theologates, and philosophates, have no explicit course in psychiatry, abnormal psychology, or mental hygiene. No one on the staff is competent to teach such subjects and, unfortunately, priests and ministers are ordained almost entirely ignorant in this respect. They have little knowledge of the problems of neuroticism, and are unconscious or only dimly aware of the millions of neurotic people who are to be found in the society which they were trained to help and save. Sooner or later, most of these professionals learn about such matters, but they do it the hard way, by making mistakes, causing pain, and intensifying the problems of people by misdirection. Some never learn, and in this respect become and remain a definite social liability. Fortunately, modern medicine has accepted the importance of psychiatric study. All medical schools now include some psychiatric training in their curricula. Although great progress has been made, much remains to be done.

CASE 3: *Harmful Result of Mistaken Diagnosis*

An unmarried white woman, twenty-six years of age, sought advice from her physician because of certain unusual experiences that she had been undergoing. She was an attractive girl who had no physical complaints, but surprised the physician whom she consulted by stating, in the course of her history, that in spite of her attractive physical qualities, she experienced great difficulty in meeting people, especially strangers. She stated frankly that her life was an isolated one, but that for her, social life was unnecessary, because she enjoyed special illumination from above. She stated that this enabled her to penetrate facts and truths not perceived by ordinary people,

that she enjoyed daily conversation with God, audibly hearing His voice calling her by name and revealing secret things. She indicated that among the directions thus divinely received were injunctions to spend a great deal of her time and energy in prayer and mortification. Accordingly, she was accustomed to refrain from food and drink several times a week, and to keep long vigils at night, watching and praying.

As she thus gradually unfolded the amazing details of her life, her case was judged to be that of a true mystical soul, and she was so informed. She was encouraged to moderate her severities, but to continue to pay heed to the divine guidance she was receiving. A few days later, the young woman committed suicide.

There is no substitute for explicit education in the nature, causes, and treatment of mental disorders. Very great progress in physical hygiene has been made as a result of which the span of life has been prolonged by many years. No comparable advance has been made in the science of mental health. Some good has been accomplished. There is much more yet to be done. The first important step in any widespread mental health program is the wider dissemination of more data on mental health problems.

FOOTNOTES

1. James C. Moloney, quoted by Joseph W. Eaton, "The Assessment of Mental Health," *American Journal of Psychiatry*, 108:2, August, 1951, pp. 81-90.
2. *Ibid.*, p. 84.
3. Eaton, *ibid.*, pp. 81-90.
4. J. A. Hadfield, *Mental Health and the Psychoneuroses* (London: George Allen & Unwin, Ltd., 1952).
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6. Thomas A. Rennie and Luther E. Woodward, *Mental Health in Modern Society* (New York: Commonwealth Fund, 1948), p. 334.
7. Karl Menninger, *Are You an Associate of the World Federation of Mental Health?* (London: W. 1 Manchester Street, 1950).
8. George H. Preston, *The Substance of Mental Health* (New York: Farrar & Rinehart, 1943), p. 112.
9. *Bulletin of the World Federation of Mental Health*, 1951, Vol. 3, 27-28. See also L. P. Thorpe, *The Psychology of Mental Health* (New York: Ronald Press Co., 1950), pp. 4-6.
10. *Ibid.*
11. Edward Glover, "Medico-Psychological Aspects of Normality," *British Journal of Psychology*, 23 (1932), 152-166.
12. Frieda Fromm-Reichmann, *Principles of Intensive Psychotherapy* (Chicago: University of Chicago Press, 1950), p. 11.
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14. Cardinal Mercier, *A Manual of Modern Scholastic Philosophy*, trans. by T. L. Parker and S. A. Parker, 3 English ed. (St. Louis: B. Herder Book Co., 1928), Vol. I, p. 293.
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16. Robert W. White, *The Abnormal Personality* (New York: Ronald Press Co., 1948), p. 3.

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PART II

ETIOLOGY

CHAPTER

- IV. THE PSYCHOGENIC NATURE OF MENTAL DISORDERS
- V. THE ETIOLOGY OF PSYCHIATRIC DISORDERS
- VI. ETIOLOGY OF PSYCHIATRIC DISORDERS: HABITS
- VII. MARGINAL CONSCIOUSNESS VS. THE REPRESSED UNCONSCIOUS OF FREUD
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INTELLECTUAL HABITS
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OCCASIONS AND CONDITIONS
- XIII. SUMMARY OF ETIOLOGY

THE PSYCHOGENIC NATURE OF MENTAL DISORDERS

The majority of mental disorders are not of somatic but of psychogenic origin. Such psychogenic disturbances are frequently referred to as functional. The terms "psychogenic" or "functional" which we here use as synonyms should be carefully defined and explained. We intend to offer two definitions of the word "psychogenic":

1. That presented by many materialists,
2. That given by the dualists, by those who hold soul and body and their mutual interaction.

1. *Many materialists, and they are logical in so doing, oppose the introduction of the word "functional" or "psychogenic" into psychiatry.* Its use and sense they claim beget confusion. For the materialist, there is no soul or mind as understood by dualistic psychology nor is there, therefore, any mind-body influence exerted. For the logical materialist there can be no strictly mental disorders at all, for him all impairment of function should be a mere reflection of impairment of structure. Structural lesions, he claims, underlie all so-called psychic disorders. Such materialists admit but one kind of mental disorder, viz., that which is based on pathological organism.

Because, however, of the overwhelming indications of the activity of something more than mere animated tissue, many materialists frequently refer to the term *psychogenic* or *functional*. This latter group defines a psychogenic or functional mental disorder as that type of psychic derangement which owes its origin not to any somatic defect or lesion but rather to a faulty organization or inadequate interaction of organic parts, which, in themselves, are whole, entire, intact, and perfect. There is in these parts no organic pathology or lesion.

In this materialistic sense the mind may be compared to a machine such as an automobile. Failure to function due to some broken part, e.g., a broken gear or axle, would be like an *organic mental disorder*. Failure to function, not because of defective or broken parts but because of lack of correct adjustment of parts, they would call functional. So they reason with regard to the mind which they consider to be

organic and composed of parts. All its parts may be sound and complete but their operative arrangement and organization may be defective. The mental disorders resulting from this lack of operative organization they would call functional.

As is evident this definition of *functional* or *psychogenic* is defective and inadequate. It does not take cognizance of such realities as soul, mind, thought, or judgment. It is entirely materialistic and ignores the psychic, immaterial, unextended nature of man's mental life. A materialistic interpretation of man renders it impossible to recognize and evaluate psychic forces.

2. *Definition of psychogenic or functional as given by the dualists.* Those whose psychology includes body and soul, whose concept of the psychic life is based on mind-body interaction define a functional or psychogenic mental disorder as one which is due not to organic defect, disease, or to a toxic condition, but one which results from the development of unhealthy mental, emotional, and volitional habits over a protracted period of time. An example will clarify the true meaning of the term.

CASE 4: *Paranoia, a Psychogenic Psychosis*

A married man, aged 45, of excellent health and pleasing appearance, was brought to a mental hospital for examination. The results of physical tests were all negative, but after a number of interviews it became evident that the patient was suffering from true paranoia. Twice before he had been placed in hospitals for the mentally ill. He had built up a vast delusional system about which he discoursed most fluently and logically. He stated that his greatest and most successful persecutor was a younger brother who, for reasons of political jealousy, had three times skillfully engineered his removal from society. In order to effect this, according to his story, his brother had a number of assistants all drawn from the family circle and close acquaintances. It was not easy to obtain data on his life previous to his first commitment. Those who were able to give some account of him could only recall a very pleasing gentleman who gave no indications of his future disability. His wife, from whom he had been separated after his first trip to the hospital, was the only one who could throw any light on the situation. She revealed that he had been an incompetent businessman. The general explanation given by himself for these failures was the jealousy or unjust interference of rival associates. It was only after some time that she began to realize that these reactions were more subjective than real. Gradually these accusations and incriminations increased in number and in-

tensity. Threats of violence followed and led to institutionalization. A checkup of the case records in the first two institutions to which the patient had been committed indicated that the diagnosis was the same then as now, namely, paranoia.

Those who accept the materialistic definition of the word "functional" under "1" above, would apply it to this case because there was no apparent organic basis for the disorder. They would feel, therefore, that there was faulty organization of organic parts which resulted in faulty organization of the personality as well as in resulting defective thinking and reasoning. Such explanation is insufficient and incorrect because it takes for granted that the disorder is really organic, not in the gross structural sense of lesion or disease, but in some less tangible way, such as defective organization or co-ordination of parts.

In the second meaning of the word "functional" (under "2" above) satisfactory explanation of the case is possible. Those who thus understand the term "functional" would explain it as follows:

a) The disordered state of mind is not due to any organic defect or toxic condition.

b) But somewhere in the course of his early development the patient was faced with the fact of a personal frustration. He yielded to the common temptation to defend himself by projecting his failure on to others not really responsible for it.

c) This reaction may have been the result of an earlier habit of blaming others for his own failure, or

d) It may have been the first step in the formation of such a habit.

e) That such a mental habit was formed is clear from the record.

Thus the adequate explanation of the above case is to be found not in the pathological defective structure of organism, nor in organizational weakness, but in the patient's unhygienic mental habit of projecting his failure on others. Such a habit, though pathological, gives protection to the ego and bolsters it up.

Since this protection appeared satisfying, at least more so than the direct facing of the facts, it was indulged in more and more until such a reaction became habitual. Experience and the testimony of psychologists and psychiatrists demonstrate that habits thus formed can establish a deep-seated and frequently unchangeable mental disorder.

The correct understanding of the psychogenic concept is of prime importance to psychiatry and must be grasped by all whose ambition it is to deal intelligently with disordered minds. Psychogenic factors,

i.e., the acquisition of unhygienic mental, emotional, and volitional habits, play an important part in psychic disorders. These unhygienic habits are begotten by an ill-organized attempt to compensate for real or imagined (only too often real) early frustration, ego deflation, failure, a sense of unworthiness, a felt inability to cope with life's problems, and urge to escape emotional traumata.

Psychogenic is a better word for disorders which owe their origin to psychological factors and is preferred to functional.

The psychoses commonly called functional are psychogenic in origin. The schizophrenias, the manic-depressive psychoses, true paranoia, and many paranoid states belong to this class.

It is this fact which justifies the opinion that all the neuroses and most of the psychoses are preventable.

THE SOMATOPSYCHIC AND TOXIC PSYCHOSES:

The somatopsychic¹ psychoses (organic, physiogenic) are those grave mental disorders which have their beginning in association with disease or defect of the biological organism. Toxic psychoses begin with the introduction of poisonous substances into the cerebrospinal system. *The presence of the toxic or somatic disease produces such a disturbance of the physical status of the individual that he reacts to it with fear or confusion and thus activates previously established, but latent, neurotic thought patterns and defective personality traits.* As pointed out in a later chapter the *symptoms* of these disorders are variable and usually due to psychogenic factors, the *signs* are more constant and due usually to physical or somatic factors. From this it may be seen that the mental disturbance is not *caused* by the somatic disorder, but that the somatic disorder serves either as an occasion or condition for its origin.

It is to be noted that these psychoses, even though associated with toxic and somatic origin, are of a psychological nature. They always remain mental disorders. Sufficient attention has not been given to this fact. The mental symptoms of a somatopsychic disorder are indistinguishable from those of a psychogenic derangement. The delusions of a patient with senile dementia do not differ qualitatively from those to be found in paranoid states.

Thus it may be seen that to establish the presence of organic and toxic psychoses, it would be necessary to show (a) mental disorder, (b) organic defect or disease or the presence of a toxic substance, with (c) causal connection between the two. Mere concomitance of

the two defects would not convincingly establish causality, especially when it is possible for the identical kind of disordered condition of mind to exist without organic lesion or disease. Psychiatrists will readily understand the possibility of two men undergoing the same traumatic experience without realizing the same results. Concussion of the brain in one case may produce mental symptoms, in another it may not disturb normalcy at all.

In many cases of mental disorder, organic pathology exists side by side with the mental state without any causal relation between them, e.g., schizophrenes with a mastoid condition, or a paranoiac with a hernia. Cautious inquiry and careful analysis must be made before causal connection can be established between the organic lesion or disease and the mental condition.

What does the psychogenic concept imply? While fully upholding the psychogenic approach to mental disorders, it is in no sense our intention to dispense with the idea or even to minimize the need for sufficiently well-integrated brain tissue as a *necessary condition for thinking*. For the processes of thinking the intellect needs the co-operation of brain tissue and the phantasm somewhat after the manner in which a carpenter needs his tools to be able to make a chair. Grave brain pathology which disrupts its necessary or essential dynamic integration may seriously interfere with all types of psychic activity. The basic integrity of brain tissues is presumed in purely psychogenic disorders.

THE EXISTENCE OF PSYCHOGENIC DISORDERS

A great number of students have been opposed to the acceptance of the idea of the psychogenic origin of mental disorders. The reasons for this attitude are the prevalence of the materialistic interpretation of man, and the opinion of certain metaphysical philosophers. *The objective data of psychiatry provide overwhelming evidence of the existence of psychogenic disorders.*

The great majority of modern psychiatrists and psychologists admit either explicitly or implicitly the widespread existence of psychogenic mental derangements. This is true even of materialistic authors. They are often deficient in their understanding and explanation of the term; their works are often replete with contradictions, but careful analysis reveals that despite the handicap of an erroneous philosophy, they are aware of the facts.

a) Father McCarthy, in his book *Safeguarding Mental Health*, gives

a somewhat inadequate definition of the term "psychogenic," but indicates throughout the work that he understands it perfectly. He considers these disturbances as exceedingly common.²

b) Kuntz, in *Elements of Abnormal Psychology*, gives a good, though negative and incomplete, definition of psychogenic mental disturbances, but indicates clearly that he understands and accepts the existence of mental disorders other than organic or toxic.³

c) Father T. V. Moore, in his recent work, *Nature and Treatment of Mental Disorders*, lays down at the very threshold of his study as an important psychological fact that some truly mental disorders really exist. To him, many mental disorders are more than cortical phenomena and are psychic superorganic states that are based on no specific organic pathology.⁴

d) Noyes and Hayden, in *A Textbook of Psychiatry*, clearly define "psychogenic" and explain that disorders of this type are not due to organic factors but are erroneous personality adjustments.⁵

e) Sadler, all through his work, *Theory and Practice of Psychiatry*, constantly urges the point of view that neurosis and psychosis are problems of personality and clearly explains psychogenic disorders. Because of philosophical eclecticism, he is led into occasional contradictions and it is clearly impossible to sanction many of the opinions he vouchsafes. He is, however, an open and consistent advocate of the prominence of psychogenic factors. He defines a functional psychosis as "one without discoverable pathology of the central nervous system, as manic-depressive psychosis."⁶

f) John J. B. Morgan, in his book, *The Psychology of Abnormal People*, maintains this interpretation throughout and he scorns the extreme organicists who cannot conceive of functional maladjustment. His definition of "functional" is imperfect, but he openly states that the organicist has failed to explain a great many mental states, that he must admit functional disorders which develop through learning, i.e., mental processes, that many mental problems arise from faulty personality adjustments.⁷

g) Fromm-Reichmann definitely describes a psychogenic etiology:

We assume that it is true that emotional problems in general and the symptomatology of a mental patient in particular are due to *difficulties* in interpersonal relationships.

Again she asserts:

It has been repeatedly pointed out that one central difficulty of most

mental patients is constituted by their *feelings of anxiety and insecurity*; by their need for acceptance and prestige; and by the *defenses* they use in pursuit of evading the first and obtaining the latter.⁸

From the above it is evident that Fromm-Reichmann considers mental diseases to be psychogenically and not organically caused.

h) White also indicates his belief in psychogenic disorders. In several parts of his book, he attributes mental diseases to "*disordered personal reactions* to life and its circumstances." He further attributes "symptoms such as delusions and hallucinations, failure of memory, depressed or excited moods" to be the surface phenomena of disordered behavior. He later defines the terms "psychogenic" and "psychogenic disorders." He observes:

In contrast to the somatogenic hypothesis, which holds that disordered personal reactions have their genesis in somatic or bodily disturbances, the psychogenic hypothesis attributes causative significance to *psychological processes*. We can give it a crude first statement, to be much refined in later sections of the book, by saying that *disordered personal reactions* occur because the patient's thoughts, feelings, and strivings are disturbed. His somatic processes, even his brain and central nervous system, may be working in an entirely normal fashion. It is the content of what he feels and imagines that throws his personal reactions into disorder. We can begin to speak of *psychopathology* at the point where ideas or some psychological processes are held responsible for disordered behavior.⁹

i) Preston explains mental disorders as having psychogenic origin when he observes:

If you ask the average person what has caused a "mental breakdown" in one of his friends, he is likely to tell you that it was overwork, or the death of a dear friend, or poverty, or loss of property, or disappointment in love, or too strenuous life. As a matter of fact, such experiences are much too common to be thought of as the sole causes of mental ill health. Not every one who loses a dear friend or who is disappointed in love or who suffers a severe loss of property becomes mentally ill. All of us are exposed to one or another of these situations and we do not all get sick so that some other factor must be at work either to produce mental illness in some of us or to protect others. The psychiatrist believes that it is not so much the situations, the actual things which happen to people, as the way people think and feel about what happens, the personal meaning of any situation that is the real cause of mental illness.

This is an essential part of the psychiatric point of view and is one

which is frequently lost sight of by those who try to understand human behavior from the outside. So often you will hear someone say, "She has everything that anyone could want. I don't see why she should be depressed." Or, "She has never done anything wrong, she is the kindest person I know; and yet she is talking about having committed sins and about being unworthy." The point is that until you know the meaning, *to her*, of what she has and what she has done, you can never know why she feels depressed or unworthy.¹⁰

j) Dorland defines psychogenic as "a disease due to faulty psychic activity."¹¹ This means that a psychogenic disease depends on the mind intrinsically and on the body as a necessary condition and on the phantasm as an instrumental cause.

k) Barrett defines psychogenetic as "produced by the mind and its mechanisms in contrast to organic or bodily development." He also defines functional as a "term used to designate an abnormality; that is, paralysis, deafness, aphonia, etc., which is not due to a physical injury, but rather to a mental state."¹²

l) Klein defines functional psychoses as "mental disorders of non-somatic etiology and seemingly due to intra-personal or inter-personal conflicts."¹³

m) Preston, attributing mental diseases to overworked defenses, observes:

What I hope to do in the following chapters is to describe some of the common defenses. You will notice that each section begins with a description of behavior which almost all of us have used at one time or another. This is important. Each of these sections should be read as if it were a different aspect or panel of the same picture because, in the ordinary human, the various types of behavior occur side by side or one after the other in the same individual. Occasionally some person seems to use one or another of these defenses frequently or forcefully or unexpectedly, and when we meet such a person, we feel that he is slightly different, possibly just a little queer. When an individual uses one or two of these defenses rigidly, exclusively, and without regard to suitability, no matter what difficulties may confront him, we are likely to call that person a psychoneurotic. A few individuals, at some point in their lives, seem to take up defenses outlined in the next chapters as a sort of habit of living, rarely laying them down, making all their contacts with the outside world under their cover, and hiding behind them even when there seems to be no threat of danger. Psychiatrists refer to these patients as psychotic. The layman calls them crazy. The law calls some of them insane.¹⁴

According to this it is evident that Preston looks upon all mental disorders as being psychogenically and not organically initiated.

n) Tredgold uses the words "psychogenic" and "functional" as synonyms. Speaking of the origin of mental disorders, he writes:

This may arise in one of two ways. In one, there are no demonstrable organic changes and the disorder appears to be entirely *functional*. It is then termed primary, endogenous, idiopathic, or *psychogenic*. In the other, the mental disorder is accompanied by, and appears to be the result of, some organic and pathological change in the brain. It is then termed secondary, exogenous, symptomatic, or organic.¹⁵

In conclusion, it should be recalled that the word "functional" is frequently defined as affecting the activity and not the organic structure. Also, functional psychoses are defined as those grave mental disorders without discernible pathology of the central nervous system.¹⁶

Besides the *weight of authority* which helps to establish the psychogenic nature of mental diseases, there is the *evidence of case histories and their analyses*. For instance, the numerous cases of "shell shock" or war hysteria developed during World War I, together with others appearing in World War II, were purely psychogenic, and not organic or toxic in origin. Many were the result of a psychic conflict between an intense desire to escape the dangers of war and an urge to preserve personal dignity and reputation in so doing.

The psychogenic nature of these maladies is obvious from a *careful study of individual case histories* which frequently reveals a record of undesirable indulgence in various types of mental and emotional mechanisms. The same conclusion has been admitted by consulting psychiatrists and psychologists, and confirmed by the complete failure of medical treatment to produce any ameliorative results.

The same conclusion is forced by the fact that these disorders were frequently improved, often entirely *cured by purely psychological methods such as suggestion, re-education, and an improved philosophy of life*. And finally, their psychogenic nature seems obvious from the *suddenness* with which they were cured, many of them on Armistice Day, World War I.

Then, too, the case histories of psychogenic psychoses, such as schizophrenia, indicate a complete absence of any organic pathology that might serve as a basis for the disorder. They do reveal, however, a prolonged, often lifelong indulgence in undesirable mental, emotional, or volitional habits, and a slowly developing picture of introversion,

and emotional apathy. The same can be said of cases of true paranoia and of some cases of manic-depressive psychoses.

The psychogenic nature of mental disorders is also strongly indicated by *the ways in which cures are effected*. For many cases of this kind, both neurosis and psychosis, respond favorably to a psychological process of re-education. Sometimes delusional states may thus be improved or even cured. This treatment is especially applicable to neurosis. It actually implies teaching the patient to meet and overcome his problem in a normally intelligent fashion. It implies setting up goals, ideals, and the development of normal relationships with others.

Re-education is essentially a psychological therapy. It has often been used successfully, and wherever it produces the desired results we may be certain that the defect was originally psychogenic in nature. For no amount of re-education, suggestion, or implanting of ideas can repair organic disease states.

An improved philosophy of life does marvels for many neurotics and other mentally maladjusted people. It is quite clear that a misunderstanding, or a complete lack of understanding of the purpose and pattern of living plays a large part in the causation of mental disorders. It should be equally clear then that the efforts of the consulting psychiatrists and others to assist their patients to an improved outlook on life and death is psychologically effective. The causal forces are clearly of a psychic, supraorganic nature; so likewise are the disorders they produce.

PHILOSOPHY OF PSYCHOGENIC DISORDERS

Some metaphysicians and students of rational psychology deny the validity of a psychogenic origin of mental disease. Students of this persuasion for the most part have been traditionally unaware of a vast body of psychiatric literature on this matter. Nor are they in possession of the pertinent factors productive of mental disease, nor are they otherwise able to account for the mental disorders of a vast group of people who by most rigid medical examination have no physical defects.

The basic reason given by the aprioristic psychologist for rejection of this psychogenic origin of mental disorders is that the soul is spiritual and that there can be no defect in a spiritual being. Two answers can be given to this objection. First, the defect implied by a psychogenic disorder is not considered a defect in the essence of the soul but merely a defective or erroneous exercise of its power. Second,

it must be admitted that error or defect can enter even into the operation of the intellect and the will. The epistemologist is confronted on the very threshold of major logic with the phenomenon of falsity. He learns that falsity exists in the judgment. Such falsity might become habitual. A most common moral phenomenon is sin. Sin is always a deordination of the human will, a defective operation of a spiritual faculty which may well become habitual.

HABIT IN THE GENESIS OF MENTAL DISORDERS

It cannot be too strongly emphasized that defective habits based on and symbolic of attempts to escape from the memory of frustration play an important part in the development, not only of the normal, but of the abnormal personality as well. As has been previously emphasized, mental diseases arise, not from defective inheritance or diseased tissue, but from the employment of faulty habits of thinking, feeling, and willing.

CASE 5: Schizoid Reaction With Depression

This patient, a white female, unmarried, age thirty-five, beauty operator, was brought for examination because of depression. History showed that for many years she had been very successful in business, and as a result was economically independent; in fact she was quite comfortably situated. Physically, she was a tall, unattractive, and somewhat awkward person. She stated that in high school, although she maintained a satisfactory scholastic average, she was socially a "total loss." She compensated for her lack of social life by becoming a constant reader. Her reading consisted of novels, most of them "true love" or "true confessions" in type. After leaving high school she attended a school for beauticians. Her record here was a repetition of that of her high school days. She made a few friends, but these soon fell away. She spent a great deal of her time at the movies and in reading novels. During this period she had one short-lived, extremely disappointing love affair. Upon her return from the beauty school, she had become more reticent than ever. She made no attempt to cultivate friendships. She lived at home, but even here withdrew from contacts with her family. She withdrew even to the extent of missing meals, and on one such occasion her parents found her staring emptily into space. Her speech was retarded, but she expressed great concern over the state of her health.

The importance of habits in the development of mental disorder is clearly shown in this case. The patient, by the employment of un-

healthy mental mechanisms, gradually shut herself away from a world of reality which she had found unpleasant. By the employment of habitual introversion, introspection, evasion, and withdrawal, she was able to escape from an unpleasant environment. Her choice of novels and movies suggested that she found happiness in a world of fantasy.

Her physical handicaps, unattractive personality, and disappointment in love were not the causes, but merely precipitating factors in her mental disease. The real cause of her difficulties was the fact that she, early in life, began habitually to employ unhealthy mental mechanisms as a protection against the anxiety produced by conflicts whose causes may have been so repressed or displaced as to be unrecognized by the individual.

From the above it is evident that a psychogenic explanation of mental disease is valid.

SUMMARY

In this chapter we have attempted to make clear the definition and meaning of psychogenic disorders. This is an important distinction to make because without a good understanding of the real meaning of psychogenesis, no true understanding of psychiatry is possible. For practical purposes we regard the terms "psychogenic" and "functional" as synonyms. The psychogenic concept of mental disorders may be demonstrated by (1) a study of the philosophy of mental disorders, (2) the authority of students of the subject, (3) evidence from the study of cases, and (4) the results of treatment.

FOOTNOTES

1. The term "somatopsychic" as used in this text refers to those mental disorders which arise in association with organic diseases. It is important to realize that the organic disease is not the causative agent of the mental disorder but merely precipitates the condition in an already disposed individual.
2. R. C. McCarthy, *Safeguarding Mental Health* (Milwaukee: The Bruce Publishing Co., 1937).
3. L. F. Kuntz, *Elements of Abnormal Psychology* (Notre Dame, Ind.: Edwards Brothers, Inc., 1939), pp. 148-316.
4. T. V. Moore, *Nature and Treatment of Mental Disorders* (New York: Grune and Stratton, 1943), pp. 2-3.
5. A. P. Noyes and E. M. Hayden, *A Textbook of Psychiatry*, 3 ed. (New York: The Macmillan Co., 1940), p. 50 ff.
6. W. Sadler, *Theory and Practice of Psychiatry* (St. Louis: The C. V. Mosby Co., 1936), pp. 40-130.
7. John J. B. Morgan, *The Psychology of Abnormal People*, 2 ed. (New York: Longmans, Green & Co., 1944), pp. 8-9, 36.

8. Frieda Fromm-Reichmann, *Principles of Intensive Psychotherapy* (Chicago: University of Chicago Press, 1950), pp. xiv, 107.
9. Robert W. White, *The Abnormal Personality* (New York: Ronald Press Co., 1948), p. 23.
10. George H. Preston, *Psychiatry for the Curious* (New York: Farrar & Rinehart, Inc., 1940), pp. 41-42.
11. William A. Dorland, *The American Illustrated Medical Dictionary*, 20 ed. (Philadelphia and London: W. B. Saunders Co., 1944), p. 1205.
12. James Francis Barrett, *Elements of Psychology for Nurses* (Milwaukee: The Bruce Publishing Co., 1930), p. 409.
13. David Ballin Klein, *Mental Hygiene* (New York: H. Holt and Co., 1944), p. 480.
14. Preston, *op. cit.*, pp. 69-70.
15. Alfred F. Tredgold, *Manual of Psychological Medicine for Practitioners and Students* (London: Bailliere, Tindall and Cox, 1943), p. 10.
16. Further information on this subject will be found in Preston, *op. cit.*, pp. 41-55; Fromm-Reichmann, *op. cit.*, pp. 107, 175; and Cardinal Mercier, *A Manual of Modern Scholastic Philosophy*, trans. by T. L. Parker and S. A. Parker, 3 English ed. (St. Louis: B. Herder Book Co., 1928), Vol. I, p. 551.

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THE ETIOLOGY OF PSYCHIATRIC DISORDERS

Before proceeding to a discussion of etiology, we feel that it is important that certain terms be clarified. We refer particularly to the terms, *occasion*, *condition*, and *cause*. These terms are often used vaguely and without any true understanding of their meaning.

An occasion may be defined as a circumstance which is apt to induce an agent to act, though he may act without it.

An occasion is a circumstance or combination of circumstances which affords an opportunity for an efficient cause to act. A crowd is an occasion for a pickpocket to ply his trade. A tavern may be the occasion for a drunkard to indulge his pet vice. Election time is the occasion for political oratory. The meeting with a friend may be the occasion of a confidential chat.¹

The same explanation of *occasion* is given by Coffey:

An occasion is any circumstance or combination of circumstances favorable to the action of a free cause. For instance, a forced sale is an occasion for buying cheaply; night is an occasion of theft; bad companionship is an occasion of sin. An occasion has no intrinsic connection with the effect as in the case of a principle, nor is it necessary for the production of the effect as in the case of a condition. It is spoken of only in connection with the action of a free cause; and it differs from a cause in having no positive and direct influence on the production of the effect by soliciting and aiding the determination of the free efficient cause to act. In so far as it does exert such an influence it may be regarded as a partial efficient cause, not a physical but a moral cause, of the effect.²

In a similar fashion, Mercier treats of *occasion*:

An occasion can exist only in reference to free causes. It may be defined as a circumstance or combination of circumstances favourable to the action of a free cause: e.g., night is an occasion of theft. The occasion has a positive influence upon the effect, if not upon the exterior efficiency at least upon the positive determination of the person's will which

precedes it; and for this reason amongst others it differs from the condition. But it is not necessary for the production of the effect, whereas the cause is necessary. Yet in accepted language it is often called a moral cause, in contradistinction to physical.³

In light of the above, occasions may be considered moral causes in the wide sense of the word.

A condition is a prerequisite for the use of a power and it must be present before the power can operate. Light is a condition for reading. Unlike an occasion, a condition must be present, but still it exercises no strict causality. Light is a condition for reading and yet light does not perform the reading. Man himself does the reading, but he requires light as a necessary prerequisite or condition for his reading activity. The light, or necessary condition, enables him to do the reading, but of itself the light does not beget the effect.

Such is the manner in which the term "condition" is treated by standard authors. "A condition is something required in order that an efficient cause can act, but it does not contribute any positive influence toward the production of the effect itself."⁴ According to Coffey,

A condition, in the proper sense of a necessary condition or *conditio sine qua non*, is something which must be realized or fulfilled before the event or effect in question can happen or be produced. On the side of the latter there is real dependence, but from the side of the former there is no real and positive influence on the happening of the event. The influence of the condition is negative; or, if positive, it is only indirect, consisting in the removal of some obstacle—"*removens prohibens*"—to the positive influence of the cause. In this precisely a condition differs from a cause: windows, for instance, are a condition for the lighting of a room in the daylight, but the sun is the cause. The distinction is clear and intelligible, nor may it be ignored in a philosophical analysis of causality.⁵

This same notion is conveyed by Bittle:

Neither a condition nor an occasion amounts to the causality of an efficient cause. They exert an indirect influence on an agent to act, but it is the action of the agent which positively influences the production of something; and efficient causality consists precisely in this productive action of the agent.⁶

THE SPIROCHETE IS A NECESSARY CONDITION FOR GENERAL PARESIS

As will be seen in the study of general paresis, the spirochete of syphilis must be present before the disorder can occur. But the

spirochete by itself is not the total cause of paresis. If it were a cause, whenever it was present paresis would result. It is, however, a well-known fact that only a small percentage of those who are attacked by the spirochete of syphilis eventually become paretics. The spirochete of syphilis is therefore a necessary condition for general paresis and not its cause.

INVOLUTIONAL CHANGES ARE CONDITIONS OF INVOLUTIONAL MELANCHOLIA

The study of involutional melancholia reveals that these psychoses occur at the climacteric, or change of life. This biological event, the climacteric, is not to be considered the cause of the psychotic state which may accompany it. If it could be so considered, all those who pass through the period of involution should experience the same psychosis. Yet actually only about 2 per cent develop involutional melancholia. The vast majority surmount the hazards of waning adulthood without serious difficulties. It would seem, therefore, that when mental disorders arise at the involutional period, this latter should not be considered a true cause but a condition of their production. Other factors of a psychological nature must be assigned as causal.

OLD AGE IS A CONDITION FOR THE SENILE PSYCHOSES

The same may be said of the senile psychoses, and the somatic changes with which they are associated. These and other somatic diseases have frequently been given a more important place in causation than they deserve. Very few, however, of those who reach old age develop senile psychoses. Yet, many psychiatrists look upon and treat senile psychoses as though they were "organic" disorders.

No matter what the contributory factors, occasions, or conditions may be, a psychosis invariably represents a grave derangement of the individual's psychic powers. Though the presence of organic factors may be a prerequisite for certain mental aberrations, the resulting psychoses are always and essentially mental phenomena.

DEFINITION OF CAUSE

A cause is that which actually influences or begets the existence of something else. A cause positively contributes toward the production of the effect or object. In this sense, it differs from both occasion and condition. There are four main causes: material cause, formal cause, efficient cause, and final cause.

1. The *material* cause is the matter out of which a thing is made; thus, wood is the material cause of a table.
2. The *formal* cause is that which somehow specifies matter, which makes it be one substance rather than another, gold and not iron, or which accidentally modifies it, makes boards into a table and not into a chair.
3. The *efficient* cause is the agent that does the action. The carpenter who makes the table is the efficient cause.
4. The *final* cause is the end or purpose intended in an action; e.g., when a man exerts himself to acquire riches, he is enticed by the goal or final cause; hence, the acquisition of riches is a true cause of his exertion.

BASIC CAUSE OF PSYCHIATRIC DISORDERS MUST BE MENTAL

Intellectual happenings and activities, the begetting of ideas, judging and reasoning, whether normal or psychotic, are psychic events. Ideas and judgments are of their very nature immaterial and immeasurable. They have neither length, breadth, thickness, weight, nor color. Psychoses can, therefore, be produced only by a cause that is itself immaterial and inextended. Ideas and judgments are functions ultimately of the soul and proximately of the mind, depending upon brain tissue as upon a condition, somewhat as the eye depends on light for its own activity.

Psychiatric disorders, though actually existing in an individual, are themselves basically suprasensuous. They are, therefore, begotten by the soul through its powers of willing, thinking, and feeling. Hence, a psychic cause must be sought for the psychoses.

CAUSES OF PSYCHIATRIC DISORDERS WERE FORMERLY CONSIDERED TO BE PSYCHOGENIC

Until recently, psychoses were accounted for largely in terms of the imperfect psychic response of the individual to environmental situations or conflicts. Imperfect reactions to reverses in fortune, disappointment in business, fear, worry, anxiety, unrequited love, grief, hatred, insecurity, and feelings of inferiority were considered as adequate causes for the particular mental disorder. This, we consider, was a logical procedure as it indicated a psychic effect and assigned its specific psychic cause.

We refer the student to the excellent essay of Paul Dubois, *The Psychological Origin of Mental Disorders*.⁷

EXISTENCE AND SOLUTION OF CONFLICTS

As previously pointed out, man is an extremely complex being, composed of body and soul. He has external cognitive powers, internal cognitive powers of the sensory order, as well as intellect. This latter power gives rise to ideas, judges, and reasons. Man possesses one will or appetitive power with two tendencies, a sense urge which follows pleasure and is not free, and a rational will which is free to choose or not to choose. The will depends upon intellectual appreciation of the object as upon a motive or impelling force for its own activity.

If each power of man acted without interference from other powers, and under the guidance of reason, he would enjoy great peace and ease. Yet he daily experiences difficulty in following reason because it is austere, speaks an abstract language, and recommends deferred pleasures.

Man has a unitary nature. He is one being though composed of the most divergent elements. He has a goal to reach which befits his unitary nature. Man, through his mind and will, seeks happiness, joy, Infinite Truth, and Infinite Goodness. Man's sensory powers, being irrational, seek their own particular pleasure and are unaware of the goal proper to the entire man. Man must attain his goal by the correct exercise of his mind and will. These latter powers, mind and will, when correctly trained, choose realities that satisfy the entire man and all his rational aspirations. Hence, there must be a certain subordination of man's powers in view of the goal that man, as a rational being, should attain. Man's divergent powers must be subordinated and disciplined to reach this goal.

This subordination is difficult because man has conflicting tendencies and, hence, experiences conflicts or tensions, owing to his inability to satisfy his varying urges. This is obvious, since each of his external senses seeks its own particular object and all of them cannot be satisfied. The interior senses—imagination, instinct, memory—and the external senses may oppose each other. Again, all of them combined or each separately may seek an object which is in opposition to that of the intellect and will. There is, therefore, opposition between sense and reason.

Man's instincts and the demands of society may and do clash. Man's personal habits may run counter to the canons of convention. Judgments oppose each other and there is conflict in every act of choice. There is violent conflict in each human breast between what he should

choose as a rational being and in the light of his ultimate goal and that which appeals here and now to his external and internal senses, imagination, instincts, feelings, and emotions. All men experience this conflict. The question is how to meet and solve such conflicts.

Conflicts, or the tension experienced because of the inability to satisfy opposing and contending urges, may be met in one of two ways: (1) by a rational approach to the problem, (2) by a solution based on escape and on avoidance.

The Rational Approach: The ordinary man has conflicts or opposing urges that can be satisfied only with difficulty. Such conflicts are part and parcel of his daily life. Ideally, man, in order to retain psychic composure, should squarely meet his conflicts at an intellectual level, see their cause, their effect, their possible complications and the means, often unpleasant, necessary to solve them adequately. Ideally, he should solve his conflict by the light of reason with his emotions and feelings properly subordinated. This *ideal* man is governed by his mind and will, by his rational self and not by mere feelings. He has learned to deny himself present pleasures, to take a long-range vision of his goal as a human being and to segregate real from apparent good. Such a man would enjoy mental stability and psychic equilibrium, for he has achieved an adequate solution to his conflict. *Unfortunately, very few, if any, such ideal individuals exist.* Such an intellectual approach would be extremely desirable and should be the aim of everyone. *Our human nature, however, is such that we usually accept some compromise.*

Escape Approach: Because of the difficulty and pain experienced in facing the unpleasant reality of certain conflicts, some method is frequently sought by an individual to soften its painful impact on his personality. Such an escape is frequently found in the employment of mechanisms accepted by the individual as good which serve to maintain the defenses of the ego so necessary for the retention of self-esteem. When confronted by a painful conflict, this individual may accept certain protective methods of judging, reasoning, and acting (mental mechanisms) to defend himself and to compensate for his subjectively, though unconsciously, recognized distaste or inability to face reality. His difficulty in accepting reality situations frequently gives rise to painful emotional reactions which may also be protective or arise as a result of his conflict situation. Both of these reactions may give rise to strong drives which may impair his volitional ability.

Confronted by such conflict situations, the individual is likely to

seek some method of protecting his ego from discomfort and deflation. The dynamisms employed for this purpose are psychic in nature and are usually called ego defenses or psychic dynamisms. These are also called mental mechanisms. These are described in Chapter VIII.

MENTAL PATIENTS ARE PSYCHOLOGICALLY ILL

It may be thus seen that in the life of mentally ill patients are to be found unsolved conflicts with a resulting sense of frustration, ego deflation, and depressing emotions, as well as an impelling urge to escape from these harassing situations. They have developed fears, phobias, and inferiority complexes. Their executive equipment may become characterized by indecision, lack of aggressiveness, and an apparent lack of concern. Emotions may also affect man's physical organism and produce many somatic manifestations. Such altered physical conditions may in turn augment the expression of the already overworked emotions and feelings. A vicious circle may thus be established. The individual at this point is ill psychologically, just as truly ill as if he had a fracture or infection and he should be treated as a sick person.

SUMMARY

Mental and emotional disorders are, therefore, not due primarily to diseased tissue or disordered function but to the conscious or unconscious employment of disturbed mental, emotional, or volitional habits for the purpose of avoiding reality situations or for the protection of the ego. This attempt on the part of the individual to avoid pain arises because of the existence of a conflict which is the result usually of his inability to choose between two or more opposed ideas. This conflict which may be in clear consciousness or marginally repressed is so distasteful to the patient that he seeks escapes from it by the employment of various mental mechanisms. The habitual employment of such mechanisms gives rise to the symptom clusters which we refer to as mental or emotional disorders.

Before proceeding to a discussion of these factors it is important to understand the meaning of the terms, "habit" and "unconscious."

FOOTNOTES

1. Celestine N. Bittle, *The Domain of Being* (Milwaukee: The Bruce Publishing Co., 1939), p. 337.
2. Peter Coffey, *Ontology or the Theory of Being* (New York: P. Smith, 1938), p. 359.
3. Cardinal Mercier, *A Manual of Modern Scholastic Philosophy*, trans. by T. L.

- Parker and S. A. Parker, 3 English ed. (St. Louis: B. Herder Book Co., 1928), Vol. I, p. 534.
4. Bittle, *op. cit.*, p. 336.
 5. Coffey, *op. cit.*, p. 358.
 6. Bittle, *op. cit.*, p. 337.
 7. Paul Dubois, *The Psychological Origin of Mental Disorders* (New York: Funk and Wagnalls Co., 1913).

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ETIOLOGY OF PSYCHIATRIC DISORDERS: HABITS

Man's soul and body when combined constitute what is called essence, or that which makes a man what he is. When the body and soul are further considered as operative, as the ultimate basis or source of human activity, they are known as the "operative essence" or nature. *A certain type of facility may be derived from the intelligent repetition of actions emanating from man's various powers. This facility in performing actions, because of intelligent repetition, is known as habit.* Habits are also called second nature. Soul and body combined give the remote, primary power to act, while habits give a facility, a secondary power, to perform actions.

Habits of body and of mind play an important part in the development of both normal and abnormal personalities. The conduct of adult life is almost entirely a matter of habitual performance. From the moment we arise until we retire, our activities are an endless chain of frequently repeated actions, products of habits which are, in a sense, ourselves. Only an infant at birth is as yet uninfluenced by the force of habit. Even the infant, however, soon begins to develop habit patterns which are to become a dominant force in his life.

Habits are of numerous types. To be well co-ordinated the individual should have organized in his life the following varieties of habits:

1. Physical or physiological,
2. Social,
3. Intellectual and volitional,
4. Psychosomatic,
5. Religious and moral.

Physiological habits are those acquired by the soma. These include motor activities such as walking or gesturing, mechanical skill, and the ability to speak or sing.

The psychosomatic group of habits includes fixed emotional reaction patterns.

Intellectual habits include: (a) Knowledge of first principles, (b) Science, (c) Wisdom, (d) Prudence, (e) Art.

Volitional habits include: (a) Prudence, (b) Justice, (c) Fortitude, (d) Temperance.

These above habits and others should be developed gradually and from the earliest days in the life of the child. There should be balance in the formation of habits. The child's various powers should receive development in proportion to their objective significance. Man is composed of vegetative, sensory, and rational elements. This should not be forgotten. Religion should be stressed from earliest years. Conscience should be carefully trained. Personal responsibility should loom into the foreground from the days of infancy onward.

It is vital to recognize that the essential element in habit formation is not in the mere mechanical repetition of the act but the assimilation of a value, be it religious, moral, intellectual, or other type. Action is, however, an indispensable condition for the establishment of a habit. The writings of Castiello,¹ Lindworsky,² Katona,³ and others amply confirm our remarks on the value of intelligent repetition in habit formation. The development of various types of habits should run concurrently.

From the standpoint of mental hygiene, habits could again be divided into:

1. Healthy,
2. Unhealthy.

Daydreaming, for example, may be considered a normal, healthy habit if moderately employed; but if it is used as an escape from painful reality, it becomes an undesirable unhealthy habit.

Natural habits,⁴ as distinguished from supernatural, do not affect the essence of the soul but the faculties of intellect and will whereby it acts.

HABIT AND PERSONALITY

It cannot be too strongly emphasized that habit formation plays an important part in the development, not only of the normal, but of the abnormal personality. As has been previously emphasized, mental diseases arise, not primarily from defective inheritance or diseased tissue, but from the employment of faulty habits of thinking, feeling, and willing.

It is essential to remember that the development of habits, even of such disturbing, unhealthy types as projection and withdrawal are freely undertaken in their first act. Although this is a perverted use of such freedom, the will, nevertheless, remains free. The full implication

of such unhealthy habits may not be foreseen or understood, but they are, nevertheless, freely and deliberately formed. Although habits may be so fixed as to be almost automatically performed, they are in each act subject to the command of the will.

THE GENETICS OF HABITS

A habit in general is a facility in the performance of an action begotten by intelligent repetition of the act. Specific individual acts enter into the formation of the habits and character which are observed in the life of the individual. There is, however, a reason or purpose for man's actions. A motive stands behind them and begets them. *Omne agens agit propter finem*. Each act represents a choice which accepted one goal or object or reality to the rejection of others. Sometimes the choice may run counter to the urges of instinct, feelings, and emotions; at other times it may be with their co-operation. At any rate habits proclaim that the process of making choice after a certain manner has become second nature in the life of the individual. Habits, therefore, are mere symbols or symptoms which manifest to the world that a man consistently acts one way and not another.

In psychiatry, habits should be examined genetically. By this we mean that the various emotions, instincts, feelings, fears, anxieties, ego-deflating experiences, and kindred situations which are constitutive elements of the habit, should be carefully analyzed and their influence on the fully developed habit be evaluated. In such sense we wish habits to be understood in this text.

HABITS ARE BASIC FOR DEVELOPMENT OF PERSONALITY

From intellectual habits are developed man's principles, ideals, and character. These, if of the proper type, will profoundly assist him in meeting his daily conflicts with intelligence, calmness, and efficiency. If the habits are according to reason and are based on deferred pleasure, or on the subordination of sense to reason and revelation, the principles and character will be worthy of a rational being. They will lead to mental integrity and psychic calm. Such an individual develops true basic principles, worth-while ideas, and strong, well-integrated personality and character. He enjoys the maximum of psychic tranquillity. He has calm of mind and peace of soul. Happiness is for him a spiritual condition. He is willing to exercise effort to preserve psychological normality, to enjoy it as one of the noblest achievements of man.

SUMMARY

Habits are important in the development of mental disorders. It is the habitual employment of defective methods of thinking, willing, and feeling which give rise to these disorders. It is important to note that in the beginning these habits are willingly accepted by the individual. With each repetition of the act there is less *advertence* to its use, but it is subject in each act to the command of the will.

FOOTNOTES

1. J. Castiello, *A Humane Psychology of Education* (New York: Sheed and Ward, 1936).
2. Johann Lindworsky, *The Training of the Will* (Milwaukee: The Bruce Publishing Co., 1929).
3. George Katona, *Organizing and Memorizing Studies in the Psychology of Learning and Teaching* (New York: Columbia University Press, 1940).
4. Cardinal Mercier, *A Manual of Modern Scholastic Philosophy*, trans. by T. L. Parker and S. A. Parker, 3 English ed. (St. Louis: B. Herder Book Co., 1928), Vol. I, p. 495.

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MARGINAL CONSCIOUSNESS vs. THE REPRESSED UNCONSCIOUS OF FREUD

Before continuing the discussion of etiology the meaning and purpose of our use of the term *marginal consciousness* should be made clear, and especially its difference from the Freudian concept of the repressed unconscious. The aim is to demonstrate that conflicts which are repressed to marginal consciousness are recognized as being there though in a state of dim and decreased awareness and thus may be considered unconscious. Such conflicts, though existing against a background of vague awareness and diminished perception, are nevertheless sufficiently in evidence to motivate the individual and to be the dynamic sources for his conduct. The *repressed unconscious* or *unconscious of Freud*, on the contrary, *was said to be totally removed from awareness, to be incapable of recall by ordinary psychological methods and still to be actually dynamic and even deterministic of man's activity*. The concept of marginal consciousness is opposed to that of the repressed unconscious of Freud. We feel that our findings, unlike those of Freud, are in complete harmony with the principles of psychology. Thus, flowing from truth, they form a solid, immutable basis for fruitful diagnosis, prognosis, and therapy.

THE BACKGROUND FOR THE DEVELOPMENT OF THE REPRESSED UNCONSCIOUS OF FREUD

A brief description of how Freud developed the concept of the repressed unconscious will serve as a basis of this discussion.

For many years of his career as a psychiatrist, Freud had no definite ideas as to the etiology of symptoms or how to effect their alleviation. He had few theories or techniques which might be considered proper to himself or truly Freudian. There is no doubt that he was impressed by Charcot's emphasis on the power of suggestion in relieving, at least temporarily, the symptoms of hysteria. Freud undoubtedly learned through Charcot that the initial precipitating circumstances did not sufficiently account for the hysterical symptoms which were witnessed.

Charcot stressed that symptoms were capable of migration, that paralysis might shift from one side of the body to the other. There were also "a number of critical differences whereby one could distinguish hysterical symptoms from ones of similar form caused by local injury to the nervous system."¹ So thought Charcot. Freud, however, was not entirely satisfied with the explanation offered by Charcot of either the etiology or the therapy of the neuroses. Despite that, there can be no doubt that Freud was considerably influenced by Charcot.

Nor did the theory and practice of Pierre Janet escape the notice of Freud. Janet had developed well-defined concepts on the nature of personality. At the time when Janet was at his best there were bitter and often fruitless discussions as to whether symptoms were of somatogenic or psychogenic origin. Janet hovered between the organic and the functional explanation of the neuroses. Janet "paused on the brink of psychogenic explanations."² He believed that patients with hysterical symptoms suffered from a constitutional weakness and because of this organic debility were unable to organize their experiences into a unified whole. Imperfect or loose personality integration accounted, in Janet's opinion, for hysterical disabling symptoms. This disintegration of the personality was called *dissociation* by Janet. He held that the dissociated individual was organically unable to keep his psychic powers under requisite control. The powers that eluded control went off on a tangent and caused their own disabling symptoms. "In hysteria, Janet conceived, the personality lost some of its normal organization. Certain systems fell out of the hierarchy, so to speak, and escaped from the restraining influence of the ego. The emancipated systems provoked behavior not unlike that of a hypnotized person."³ Freud differed with Janet's explanation of the etiology of symptoms. It belonged equally, he thought, to the organic and psychic realms. At any rate, Freud eventually broke with Janet. Freud did not wish to attribute hysterical symptoms to constitutional weakness but rather to mental conflict and repression. This last point was not at that period too clear to Freud, but he perceived tremendous weakness in the dissociation of Janet.

Largely because of his connection with Breuer, Freud became conversant with the procedure later on to be known as *abreaction*. Breuer had developed considerable skill in removing hysterical symptoms. One of his patients, a young girl of unusual education and gifts, with "a variegated picture of paralyses with contractures, inhibitions and

states of mental confusion"⁴ could be relieved of "these clouded states if she was induced to express in words the affective phantasy by which she was at the moment dominated."⁵

The process was always the same: recovery during hypnosis of some drastic incident in which emotion had been suppressed, full and dramatic expression of the emotion, permanent disappearance of the symptom that had been laid down on that occasion. The method of cure, it will be noticed, differs greatly from the earlier use of hypnotism. There is no attempt to suggest that the symptoms vanish. The central fact in the cure was the release of suppressed emotion, and the part played by hypnosis was merely that of rendering recall and emotional expression more easy. The release of suppressed emotion — of "strangled affect" — was the core of Breuer's discovery, and received the name of *abreaction*.⁶

Freud had grasped clearly and sympathetically all that Charcot, Janet, and Breuer had to offer to the psychiatric world. For several years he himself attempted therapy by way of abreaction. Many questions, however, remained unanswered in Freud's mind as to the etiology of symptoms. Neither was the process underlying abreaction clear to him. Hypnosis, as practiced by most psychiatrists of the time, presented many unsolved problems to Freud. Not all patients could be hypnotized. Some could be hypnotized but not with depth sufficient to be of therapeutic value to effect contact with traumatic experiences. Freud was not impressed by attempts at therapy on a patient who was in an hypnotized state and therefore, to a large degree, passive. Many patients who responded well to hypnotism did not seem to derive much benefit from the actual therapy. Hypnotism paid but very little attention to the personal relationships of the therapist and patient. Freud maintained that successful therapy "depended upon an unbroken friendly relation between doctor and patient, the most brilliant results being obliterated whenever this relationship was even slightly beclouded."⁷ Above all Freud felt that no real progress was being made toward the solution of the etiology of hysterical symptoms. In the joint writings of Breuer and Freud nothing was contributed which went beyond the direct descriptions of their observations. The etiology of symptoms was scarcely touched upon. Freud was not satisfied with Breuer's answer to the question:

. . . when is it that a mental process becomes pathogenic, that is, when is it that it becomes impossible for it to find a normal discharge? Breuer preferred what might be called a physiological theory: he thought that

the processes which could not find a normal outcome were such as had originated during unusual, "hypnoid" mental states. This opened the further question of the origin of these hypnoid states. I, on the other hand, was inclined to suspect the existence of an interplay of forces and the operation of intentions and purposes such as are to be observed in normal life. Thus it was a case of "Hypnoid Hysteria" versus "Defence Neurosis."⁸

Freud was insistent on finding a cause for the hysterical episodes and also for the symptoms of neurasthenia. The conclusion Freud reached on the etiology of the neuroses may best be stated in his own words: "I now learned from my rapidly increasing experience that it was not *any* kind of emotional excitation that was in action behind the phenomena of the neurosis but habitually one of a sexual nature, whether it was a current sexual conflict or the effect of earlier sexual experiences."⁹

Later on, speaking of the etiology of the neuroses, he presented the same opinion in more precise language. For Freud the question of the etiology of the neuroses was settled by his conclusion that it could in all cases be traced to sex. Freud quickly realized that by holding this doctrine he would be parting company with many of his confreres. This is what actually happened. Most of them deserted him. He himself wrote: "Breuer . . . shrank from recognizing the sexual aetiology of the neuroses."¹⁰ The same was true of the attitudes of Jung and Adler toward the sexual etiology of the neuroses proposed by Freud. Freud said:

Jung attempted to give to the facts of analysis a fresh interpretation of an abstract, impersonal and non-historical character, and thus hoped to escape the need for recognizing the importance of infantile sexuality and of the Oedipus complex as well as the necessity for any analysis of childhood. Adler seemed to depart still further from psycho-analysis; he entirely repudiated the importance of sexuality, traced back the formation both of character and of the neuroses solely to men's desire for power and to their need to compensate for their constitutional inferiority, and threw all the psychological discoveries of psycho-analysis to the winds.¹¹

By now Freud had veered very considerably from therapy by way of abreaction and as he had determined to abandon hypnosis a grave problem presented itself. It was most difficult to secure a substitute for hypnosis, a technique employed by himself and Breuer to uncover the painful experiences. It may be recalled that abreaction "could not

take place without recall of the original pathogenic situations, and these seemed often to be completely forgotten. In the Breuer cases it was necessary to enlist the aid of hypnosis in order to bring forward the crucial memories."¹² The first method employed by Freud to uncover the repressed material was called by Freud himself "pressing and encouraging him"—as Bernheim had previously done—and at the same time laying his hand on the subject's forehead. Some of the forgotten memories seemed to return, but on the whole this method was not very successful. It was quite difficult and exhausting and many patients did not respond with a flood of memories when suggestions were made to them or their foreheads were being touched.

Freud next adopted the method of free association in which the patient was asked

. . . to say whatever came into his head, while ceasing to give any conscious direction to his thoughts. It was essential, however, that he should bind himself to report literally everything that occurred to his self-perception and not to give way to critical objections which sought to put certain associations on one side on the ground that they were not sufficiently important or that they were irrelevant or that they were altogether meaningless.¹³

Freud found free association an effective means of reaching the traumatic experience. Unlike hypnosis or the urging method, free association need never break down, since "it must theoretically always be possible to have an association."¹⁴

While making use of the method of free association to reach the pathogenic experience, Freud observed that the patients not infrequently experienced mild alarm, tension and anxiety, and declared they had no further association and could not proceed. Something unpleasant seemed to block the flow of associations. They seemed perturbed and would often present critical objections or give associations of a very elusive nature. In light of such experiences Freud elaborated his theories concerning conflict, repression, resistance, repressed unconscious, and kindred elements connected with his theory of psychoanalysis. It may be good to recall that in the early days of free association Freud made no use of dreams as the starting point of his associations. He began from the materials of everyday life. Associations that began with the whole dream or with a fragment of it represent a much later period in Freud's life. Freud attempted by his system of free association to assist the individual to recognize the various rami-

fications of his repressions and "replace them by acts of judgment which might result either in the acceptance or in the rejection of what had formerly been repudiated."¹⁵ This method of therapy was described by Freud as psychoanalysis and not as abreaction. "I showed my recognition of the new situation by no longer calling this method of investigation and treatment catharsis but psycho-analysis."¹⁶

THE REPRESSED UNCONSCIOUS OF FREUD

The unconscious is basic in the Freudian system as well as in those schools that have followed him. We shall present briefly Freud's concept of the unconscious and indicate where it is contrary to what we consider an acceptable psychology.

There is now general agreement as to the existence of unconscious psychological processes. It is, however, important to distinguish such unconscious states from the repressed unconscious which is basic to the Freudian system of psychoanalysis. In this regard the notions of the conscious and unconscious are of special significance. The "division of mental life into what is conscious and what is unconscious is the fundamental premise on which psycho-analysis is based."¹⁷

"Psycho-analysis has impressed us very strongly with the new idea that large and important regions of the mind are normally removed from the knowledge of the ego." The importance of the Unconscious is therefore apparent. Its nature may be clarified by a brief preliminary description of a few closely related and genetically connected terms. These terms are the *id*, the *ego*, and the *superego*.

Though in his discussions Freud seemed at times to treat the *id*, *ego*, and *superego* as entirely distinct entities and even as opposed to each other, such actually was not the case. He said: "One must not take the differences between the ego and the *id* in too hard and fast a sense."¹⁸ He added:

When you think of this dividing up of the personality into ego, superego and *id*, you must not imagine sharp dividing lines such as are artificially drawn in the field of political geography. We cannot do justice to the characteristics of the mind by means of linear contours, such as occur in a drawing or in a primitive painting, but we need rather the areas of colour shading off into one another that are to be found in modern pictures. After we have made our separations, we must allow what we have separated to merge again.¹⁹

In light of the above quotations it is difficult at times to reconcile

the specific functions assigned by Freud to the id, ego, and superego with the influence exerted by each upon the other.

THE ID

According to those psychiatrists who follow the Freudian concepts of the structure of the psychic life, the human being at the beginning of his career derives what is called an id from his forebears. "The id is the bearer of heredity and evidently must be regarded as the fertilized ovum when we trace it back to the first stages of its development."²⁰

The id is said to transmit to the individual not only physical traits but also experiences which "have been repeated often enough and with sufficient intensity in the successive individuals of many generations."²¹ As a result of this repetition, the experiences "transform themselves so to say into experiences of the id, the impress of which is preserved by inheritance. Thus in the id, which is capable of being inherited, are stored up vestiges of the existences led by countless former egos."²² Freud described his concept of the id in part as follows:

We . . . call it a chaos, a cauldron of seething excitement. We suppose that it is somewhere in direct contact with somatic processes, and takes over from them instinctual needs and gives them mental expression, but we cannot say in what substratum this contact is made. These instincts fill it with energy, but it has no organization and no unified will, only an impulsion to obtain satisfaction for the instinctual needs, in accordance with the pleasure-principle. The laws of logic—above all, the law of contradiction—do not hold for processes in the id. Contradictory impulses exist side by side, without neutralizing each other, or apart; at most they combine in compromise formations under the overpowering economic pressure towards discharging their energy. There is nothing in the id which can be compared to negation, and we are astonished to find in it an exception to the philosophers' assertion that space and time are necessary forms of our mental acts. In the id there is nothing corresponding to the idea of time, no recognition of the passage of time, and (a thing which is very remarkable and awaits adequate attention in philosophic thought) no alteration of mental processes by the passage of time.²³

For Freud the id was the playground of the "untamed passions."²⁴ "The Id contains the passions."²⁵

"Freud . . . had come to believe that constitution involves the individual's total heredity—not the parents, grandparents and great-grandparents—but something that goes back to remote generations. Biologists tell us . . . that ontogeny repeats phylogeny."²⁶

These racial experiences are considered to be of an unconscious type or nature so far as the individual is concerned. Freud concluded that the basis of mental life was not the conscious but the unconscious.

For the Freudian School the id is the nucleus of the unconscious. "If inherited mental formations exist in the human being — something analogous to instinct in animals — these constitute the nucleus of the unconscious."²⁷

THE EGO

The *speculative intellect* seems to be the faculty most closely resembling the ego, although it has no strict scholastic equivalent. This appraisal, however, needs considerable qualification, as will appear in light of the following citations from Freud.

Freud defined the ego as follows: "I define the ego as a coherent organization of mental processes."²⁸ Again Freud described the ego in these words:

One can hardly go wrong in regarding the ego as that part of the id which has been modified by its proximity to the external world and the influence that the latter has had on it, and which serves the purpose of receiving stimuli and protecting the organism from them, like the cortical layer with which a particle of living substance surrounds itself. This relation to the external world is decisive for the ego. The ego has taken over the task of representing the external world for the id, and so of saving it; for the id, blindly striving to gratify its instincts in complete disregard of the superior strength of outside forces, could not otherwise escape annihilation.²⁹

The ego is not sharply separated from the id; its lower portion merges into it . . . it is easy to see that the ego is that part of the id which has been modified by the direct influence of the external world.³⁰

The ego is not the same as the mind. Freud expressly indicated a difference between them. The mind is more inclusive than the ego. Freud defined mind as follows: "We . . . look upon the mind of an individual as an unknown and unconscious id, upon whose surface rests the ego, developed from its nucleus the Pcpt-system."³¹

The Functions of the Ego

To the ego are assigned the functions of "reason and sanity."³² The ego represents what we call reason and sanity in contrast to the id which contains the passions. ". . . We may say that the ego stands for reason and circumspection, while the id stands for untamed passions."³³

The ego of Freud seems able to judge and to reason. It is also both a cognitive and appetitive power. It functions both as mind and will. This is necessary since Freud has no appetitive faculty in his psychological theory. "In this way he develops an ego, a collective name for all the perceptive and executive functions which adapt him to his physical environment."³⁴

The ego further seems to have the power of rejecting or accepting objects. One of its functions is that of repression. "... Resistance can only be a manifestation of the ego, which carried through the repression at one time or another and is now endeavoring to keep it up."³⁵

"From the ego proceed the repressions."³⁶ The matter repressed tries to return to consciousness but is prevented from doing so by the ego which continues to maintain its repressive force manifested as resistance.

Freud clearly saw the vagueness which surrounded his "anatomy of the mental personality."³⁷ He himself commented on this obscurity which beclouded his writings on this point. He asked that we "do not judge too harshly of a first attempt at picturing a thing so elusive as the human mind."³⁸

THE SUPEREGO

Conscience or practical intellect seems to be the nearest scholastic equivalent to the superego of Freud. Freud himself said: "... the superego, you may call it, the conscience."³⁹

Freud arrived at his concept of the superego in a rather interesting fashion. He said he observed how psychotics frequently had delusions of observation. They thought that someone was watching them in the expectancy of catching them doing something that was forbidden and for which they would be punished. Freud stated that the strong impression he received from this clinical picture never abandoned him. He asked himself how it would be if this picture were in harmony with reality:

Under the strong impression of this clinical picture, I formed the idea that the separating off of an observing function from the rest of the ego might be a normal feature of the ego's structure; this idea has never left me, and I was driven to investigate the further characteristics and relations of the function which had been separated off in this way.⁴⁰

Freud asked if the separating off of an observing function from the rest of the ego might not be of the essence of the ego structure. The ego, it is evident, "can take itself an object . . . can treat itself like any other object, observe itself, criticize itself . . . or put one part of

the ego over against another part."⁴¹ Freud concluded the ego can be split. Now one's conscience, he reasoned, can most easily be separated from one's ego and set over against it. This conscience can punish one with painful reproaches after he has done wrong and make him feel remorse for it.

The Development of the Superego

According to Freud, the superego in the beginning is formed by incorporating the legislation of the parents and their representatives. Later on, with the passage of years, the youth accepts the standards or the superego of his parents. The superego, having incorporated the parental authority, assumes the parental functions. The superego is considered a successful example of identification with parental vetoes and an introjection of parental principles.

Functions of the Superego

The functions of the superego are (1) self-observation, (2) formation of moral judgments, and (3) formation of ideals. "The superego is the representative of all moral restrictions, the advocate of the impulse towards perfection . . . in short what people call the higher things of life."⁴²

The superego is also "the vehicle of the ego-ideal, by which the ego measures itself, towards which it strives, and whose demands for ever-increasing perfection it is always striving to fulfill."⁴³

Strangely enough, in another place Freud suggested how the functions of the ego and superego may be interchanged. "The ego advances from the function of perceiving instincts to that of controlling them."⁴⁴

FREUD'S THREEFOLD DIVISION OF PSYCHIC LIFE

In discussing mental disorders and in applying his psychoanalytical principles to individual cases Freud envisaged a threefold division of man's psychic life. These psychic strata he called:

1. The conscious,
2. The preconscious or foreconscious, and
3. The unconscious.

Many of Freud's statements on the construction of man's psychic life are vague and admit of various meanings. Some of these may be taken metaphorically. Yet, Freud apparently wished to be taken literally when he divided the psychic life into conscious, foreconscious, and unconscious.

Speaking of psychoanalysis, he said "it professes to consider mental

topography . . . and to indicate in respect to any given mental operation within what system or between what systems it runs its course."⁴⁵ Mention again was made of "systems in the mind that are superimposed one upon the other."⁴⁶ He spoke of "regions in the mental apparatus."⁴⁷ He said: "Incidentally on this occasion the topographical terminology does not merely serve to describe the nature of the function, but actually corresponds to the anatomical facts."⁴⁸ Again he wrote:

We have consequently also attributed to the word "unconscious" a topographical or systematic meaning; we have talked of systems of the preconscious and of the unconscious, and of a conflict between the ego and the Ucs. system; so that the word "unconscious" has more and more been made to mean a mental province rather than a quality which mental things have.⁴⁹

From these and other citations, it would seem that Freud's words and methods justify an understanding of his mental strata as distinct realities.

These layers may be briefly described as follows:

The Conscious

The root meaning of consciousness is awareness. The conscious mind is that aspect of psychic life which is aware of whatever is happening at this given moment. Hence, a person is conscious of whatever he is aware of at a given moment, his thoughts, feelings, perceptions, desires, aspirations, and the like. The first or outer layer of man's mental apparatus is looked upon as the holder of items in awareness here and now.

Freud defined consciousness as "the superficies of the mental apparatus; that is, we have allocated it as a function to the system which is situated nearest to the external world."⁵⁰

The Foreconscious or Preconscious

The second layer, the foreconscious or preconscious, is considered by materialistic psychiatrists as preserving memories and complexes which are in the immediate fringe of focal awareness and may, therefore, be easily recalled. The foreconscious is supposed to retain, for example, our knowledge of French while we speak English or of certain arts while we engage in other activities.

We can say that it was latent and by this we mean that it was capable of becoming conscious at any time.⁵¹

"That which is latent and only unconscious in the descriptive and not in the dynamic sense we call preconscious." No resistance is to be overcome by the complex or idea prior to its coming into consciousness. Such material is but temporarily latent and may be easily recaptured.

The preconscious can scarcely be called unconscious in any true sense of the word:

We can say that it was latent, and by this we mean that it was capable of becoming conscious at any time. Or, if we say that it was unconscious, we are giving an equally correct description. Thus "unconscious" in this sense of the word, coincides with "latent and capable of becoming conscious."⁵²

"That which is latent, and only unconscious in the descriptive and not in the dynamic sense, we call preconscious."⁵³ Freud said that "from a purely descriptive point of view, the 'preconscious' is also unconscious, but we do not give it that name, except when we are speaking loosely."⁵⁴

On the whole the foreconscious or preconscious plays a very minor role in the psychoanalysis of Freud.

The Unconscious or Repressed Unconscious

The basic meaning of unconsciousness is unawareness. In general the unconscious activities going on at a given moment within the individual are those of which he is unaware. No one disputes the fact that there are many processes which go on within us continually and of which we have no awareness. The ordinary processes of the vegetative life are unconscious. No one, therefore, doubts the existence of a physiological unconscious.

The concepts of repression and of the unconscious are of paramount importance in contemporary psychiatry. Freud claimed that repression was the cornerstone of his system of the unconscious. "We obtain our concepts of the unconscious from the theory of repression."⁵⁵ In Freud's theories repression and the unconscious cannot be separated. He defined the unconscious in terms of repression. Freud arrived at his idea of the unconscious and repression in the following fashion: he observed that when patients came to him for help in their problems, they displayed symptoms of various kinds—fears, phobias, unjustified exhaustion, loss of function, and numerous similar indispositions. They seemed unable to give him justification for the existence

of their symptoms. Strangely enough, the cause seemed to evade their grasp. Freud tried to unearth the cause of their irritating symptoms. To help himself reach the etiology of their symptoms, it was his custom to

Require the patient to put himself into a condition of calm self-observation, without trying to think of anything, and then to communicate everything which he becomes inwardly aware of, feelings, thought, remembrances, in the order in which they arise in his mind.⁵⁶

Genesis of the Freudian unconscious: From his experiences with his patients, Freud reasoned to repression as follows: down the road of life the ego encounters certain irritating experiences which for the moment it is not prepared to meet adequately, dispose of, and assimilate. Nor does the ego suppress them, that is, keep them under permanent voluntary control and subjection. It represses them to the unconscious, reasoned Freud.

Repression, therefore, in the Freudian sense is an automatic, unthinking, involuntary rejection of a disturbing complex into the realm of unawareness where it is entirely removed from consciousness, remains dynamic, and is unrecalable by ordinary psychological methods.

The impulse on being repressed in the Freudian sense "would retain its energy and no memory of it would be left behind; the process of repression would be accomplished without the cognizance of the ego."⁵⁷

Unconscious is no longer a term for what is temporarily latent; the unconscious is a special realm with its own desires and modes of expression and peculiar mental mechanisms not elsewhere operative.⁵⁸

The unconscious eventually contains not only the id with all that it implies but also the data that were subjected to repression. "So the unconscious in the course of experience comes to contain two types of material: (a) its original racial experience, and (b) the repressed elements that were formerly conscious."⁵⁹

Repression does not inactivate the complex: The complex in the unconscious is not inactivated, according to Freud, by its exclusion from awareness. Repression to the unconscious does not mean the death or destruction of the complex but merely its total exclusion from awareness and memory. Though forgotten and therefore unconscious, the complex is a highly dynamic and potent reality, he maintained. The complex is in a constant state of unrest, continually striving to return to consciousness. There is a constant struggle between

the mental force which attempts to keep repressed material below the surface of consciousness and the opposing psychic force which attempts to push it in the other direction. This is known as resistance.

The compromise finally reached between the repressing force and the "strong upward-driving force" of "the repressed" appears in the form of a symptom. Freud expressly stated that symptoms were related to resistance, to repression, and to the unconscious:

It follows from the existence of a symptom that some mental process has not been carried through to an end in a normal manner so that it could become conscious; the symptom is a substitute for that which has not come through. Now we know where to place the forces which we suspect to be at work. A vehement effort must have been exercised to prevent the mental process in question from penetrating into consciousness and as a result it has remained unconscious; being unconscious it had the power to construct a symptom.⁶⁰

The symptom has its origin in the repressed; it is as it were the representative of the repressed in relation to the ego.⁶¹

Freud further stated that without repression there would be no symptoms. "It will not be necessary to make our conception of this process of repression more precise. It is the essential preliminary condition for the development of symptoms."⁶²

Repression is effected by the individual's character traits and personality. Freud gave this opinion:

There are other sides to the problem of repression itself which present questions to be answered: What kind of mental excitations suffer repression? What forces effect it and from what motives? On one point only, so far, have we gained any knowledge relevant to these questions. While investigating the problem of resistance we learned that the forces behind it proceed from the ego, from character-traits, recognizable or latent: it is these forces, therefore, which have also effected the repression, or at least they have taken a part in it. We know nothing more than this at present.⁶³

The repressed material remains unaltered by the passage of time:

Conative impulses which have never got beyond the id, and even impressions which have been pushed down into the id by repression, are virtually immortal and are preserved for whole decades as though they had only recently occurred.⁶⁴

Again he repeats: "The repressed remains unaltered by the passage of time."⁶⁵

The unconscious which is begotten by repression is the only one of true significance in the theories of Freud. As we saw previously, he reserved the term "unconscious" for "the dynamically unconscious repressed."⁶⁶

Freud claimed that the preconscious is unconscious merely in the descriptive sense. In his estimation the dynamic repressed unconscious is the only one that really counts. "We can now set to work comfortably with our three terms, Cs, Pcs, and Ucs, so long as we do not forget that, while in the descriptive sense there are two kinds of unconscious, in the dynamic sense there is only one."⁶⁷

Freud maintained the unconscious in the truly dynamic sense of the word, that conflict which, though repressed and removed from awareness, still tries to come into consciousness and is dynamic and contributes to the development of symptoms. He further claimed that any psychic data that come into associative contact with the id or with the material connected with "primal" repression suffer "the same fate" and therefore become unconscious. Such obviously is the matter repressed by the ego. Freud contended we have no idea whatsoever as to the content or nature of the repressed unconscious.

The unconscious is the true psychic reality; in its inner nature it is just as much unknown to us as the reality of the external world, and it is just as imperfectly communicated to us by the data of consciousness as is the external world by the reports of our sense organs.⁶⁸

HOW TO RECALL THE UNCONSCIOUS

We remember the difficulty Freud had at the beginning of his career in psychoanalysis when he attempted to make use of free association to recall the pathogenic experiences of the individual. There were frequently lengthy pauses and the individual was unable to proceed. This, as we have seen, was one of the reasons why Freud developed the concepts of repression, resistance, and the repressed unconscious. According to Freudian teaching, as seen in the previous quotations, the content of the unconscious is unknown to the individual and cannot be recalled through the medium of ordinary psychological methods. The special problem of Freud was therefore how to discover, liberate, and treat the unconscious whose content and activity, though unknown to the individual and beyond regular recall, are disturbing his life and begetting symptoms. Freud said that as symptoms arise because of resistance therapy must aim to overcome this resistance and thus permit the mental process to be carried through

in a normal manner and become conscious. We know that Freud had abandoned the hypnotism and suggestion of Janet and the abreaction of Breuer. The therapy proposed by Freud was entirely different from that of his predecessors.

A different view had now to be taken of the task of therapy. Its aim was no longer to "abreact" an affect which had got on to the wrong lines but to uncover repressions and replace them by acts of judgment which might result either in the acceptance or in the rejection of what had formerly been repudiated. I showed my recognition of the new situation by no longer calling my method of investigation and treatment catharsis but psychoanalysis.⁶⁹

Freud again observed that "in the technique of psycho-analysis a means has been found by which the opposing force can be removed and the ideas in question made conscious."⁷⁰ He added that "the analysis is faced with the task of removing the resistances which the ego displays against concerning itself with the repressed."⁷¹

When the individual understands what caused the resistance the symptom itself will vanish. Freud says:

The proposition that symptoms vanish when their unconscious antecedents have been made conscious has been borne out by all subsequent research. . . . Our therapy does its work by transforming something unconscious into something conscious, and only succeeds in its work insofar as it is able to effect this transformation.⁷²

HOW DOES PSYCHOANALYSIS REACH THE REPRESSED CONFLICT?

Psychoanalysis has claimed special techniques which are considered effective in reaching the repressed material. Freud stated that through psychoanalysis we are able to achieve the "transformation of the unconscious thoughts into conscious thoughts. . . . By extending the unconscious into consciousness the repressions are raised, the conditions of symptom-formation are abolished, and the pathogenic conflict exchanged for a normal one which must be decided one way or the other."⁷³

DREAMS AND THE UNCONSCIOUS

The problem then becomes how to discover what means and methods are best suited to reach the unconscious. For Freud, dreams seemed best adapted to that purpose. Here is the reason for the place of honor and personality. Despite our desire to be both sympathetic and under-

repressed to the unconscious, are considered dynamic. They are thought of as "chafing at the bit" of inaction and perpetually attempting to regain admission to conscious life. Originally, however, they were repressed because their content was in opposition to man's ethical principles. Their unpleasant affect is the reason why the censor keeps them in the unconscious. To be permitted to reach consciousness the complexes must don a new garb, must disguise themselves somewhat. The repressed complex finally appears in the telescoped, condensed, and disguised form of a dream.

According to Freud, this distorted version of the complex is all the conscious life can tolerate. The dream version of the complex is the compromise reached by the unconscious and the censor. This dream was known to Freud as the manifest dream and was considered "no more than a distorted, abbreviated, and misunderstood translation, and usually a translation into visual images. These latent dream-thoughts contained the meaning of the dream, while its manifest content was simply a make-believe, a façade, which could serve as a starting point for the associations but not for the interpretation."⁷⁴

ASSOCIATION AND RECALLING OF THE UNCONSCIOUS

Freud made use of "free association" to reach the unconscious. He claimed that the first association would give the analyst what he sought, namely, connection with the latent dream-thoughts in the repressed unconscious. Free association would help to uncover the resistance which is the first step toward overcoming it. The work of analysis involves "an art of interpretation, the successful handling of which may require tact and practice but which is not hard to acquire."⁷⁵ Freud claimed that the method of free association imposes the least possible compulsion upon the patient and has the added advantage that it never breaks down, as does the hypnosis as employed by Janet and Breuer. According to Freud, therefore, the first association must be regarded as having contact with the repressed material.

THE LAWS OF ASSOCIATION

The idea of free association introduced by Freud was new only in his idea that the first association was determined and in its specific application to reach "the unconscious." Aristotle first, then St. Thomas Aquinas, noted that the process of recollection usually advanced along a time-series of events starting with those more recent and gradually working back to those more remote. The laws of asso-

ciation of Aristotle were *similarity*, *contrast*, and *contiguity*. Simply stated, the law of similarity expresses the fact that like suggests like, the law of contrast states that like has a way of suggesting unlike. The law of contiguity states that what is near something else may cause an association. More simply, all these laws may be stated by saying that when part of a previous experience is remembered the remainder may be more easily recalled. It is thus that we use the association of ideas to bring into focal awareness a conflict that was in marginal consciousness. Such associations are not determined.

THE FIRST ASSOCIATION LEADS TO THE COMPLEX FREUD CLAIMED

Freud officially denied the freedom of the will and was therefore a determinist. He held that the first association given by the patient would lead to the repressed complex. He wrote:

When you think it arbitrary to assume that the first association of the dreamer must give us just what we are looking for, or at any rate lead to it, and further, that the association is much more likely to be quite capricious and to have no connection with what we are looking for, and that it only shows my blind trust in Providence if I expect anything else—then you make a very great mistake. I have already taken the liberty of pointing out to you that there is within you a deeply rooted belief in psychic freedom and choice, that this belief is quite unscientific, and that it must give ground before the claims of a determinism which governs our mental life. I ask you to have some respect for the fact that one association, and nothing else, occurs to the dreamer when he is questioned. Nor am I setting up one belief against another. It can be proved that the association thus given is not a matter of choice, not indeterminate, and that it is not unconnected with what we are looking for.⁷⁶

Freud thus has been interpreted by his followers. Making comment on free association as a help to recall of the unconscious, Jelliffe and White remark:

The method of procedure is the method of free association. Whether it be the analysis of some component of a dream or of a slip of the tongue, or what not, the method of free association is the one employed. The patient should be alone with the physician. It is practically impossible to conduct an analysis, at least beyond the surface, in any other way. Under circumstances of quiet and freedom from interruption, as far as possible, the different points which are to be analyzed are

taken up. The patient is instructed to take a certain element of the dream which he has just recounted, for example, and hold it in his mind, and then tell freely all of the ideas that come to him. He is told to tell all of the ideas without any effort on his part of selection, no matter whether the ideas appear to him to have any relationship with the portion of the dream that he has been told to keep in mind or not, and no matter whether they appear ridiculous or have other qualities that incline him to lay them aside. He must tell them all just as a man might sit at the window of a railroad train and jot down, as far as possible, everything that he sees pass the window as the train speeds on. Preferably, the patient should be lying down, unable to look at the physician. The theory of this procedure is that if the patient does not direct the thought in any way every idea that comes must of necessity have some relation to the event held before the mind about which enlightenment is sought.⁷⁷

Besides free association, slips of the tongue and of the pen also were considered by Freud as effective means of reaching the repressed unconscious. Freud claimed in the earlier portion of his works that symptoms vanish when their unconscious motives have been made conscious. As is evident, Freud was then considerably under the influence of Breuer.

The proposition that symptoms vanish when their unconscious antecedents have been made conscious has been borne out by all subsequent research.⁷⁸

Later on, when a transition from abreaction had been effected, Freud developed what seems to be a more intellectual method of therapy.

A different view had now to be taken of the task of therapy. Its aim was no longer to "abreact" an affect which had got on to the wrong lines but to uncover repressions and replace them by acts of judgment which might result either in the acceptance or in the rejection of what had formerly been repudiated.⁷⁹

Briefly, this was the doctrine of Freud so far as this particular chapter is concerned. A brief review of criticism is now in order.

COMMENT ON FREUD'S ANATOMY OF MENTAL PERSONALITY

As was observed earlier, Freud asked that we judge not too harshly his first attempts at picturing a thing so illusive as the human mind given to dreams: The complexes according to the Freudians, though

standing toward him we feel that a few criticisms must be leveled against his "Anatomy of the Mental Personality."

1. *The Id*: It is an entirely gratuitous statement to claim that the experiences of the ego which have been repeated "often enough"⁸⁰ and with "sufficient intensity"⁸¹ may be "transformed into experiences of the id,"⁸² the impress of which is preserved by experience. Experiences, as is evident, are something psychic and cannot therefore be subjected to the regular laws of organic transmission: "Images of egos that have passed away" cannot be given a "resurrection."⁸³

2. *The Ego*: Regardless of the superior type of activity attributed verbally to the ego by Freud, in practice the ego is under the control of the id and of the superego. Together with that, the ego seems to be both cognitive and appetitive. The ego may exchange function with the superego. It is difficult therefore to see where the ego has anything significant that is truly proper to itself. We may also ask how the same power can be both cognitive and appetitive.

3. *The Superego*: The superego is strictly not a synonym for conscience as we find it in a fully developed man. The Freudian theory makes morals a matter of custom and tradition. The superego "cannot explain its commands because the source of its authority is buried in the unconscious."⁸⁴ The Freudian superego would "produce a personality completely caked with custom and shackled by tribal mores."⁸⁵

4. *Consciousness*: Apart from the totally unwarranted materialistic assumption of the existence of layers or strata in man's psychic life and of the extension attributed to psychic phenomena such as ideas and complexes, this first layer is readily admitted. As is, however, evident from psychology, the notions of layers and of extension have no meaning whatever in dealing with rational psychic activities.

Freud defined consciousness as the superficies of the mental apparatus; that is, he allocated it as a function to the system which is situated nearest to the external world. Intellectual, spiritual functions are not localized. The topography, if meant to be taken in any literal sense, is unacceptable.

5. *Foreconscious or Preconscious*: The idea of the foreconscious or preconscious is readily admissible. It may be well to remark, however, that here again we object to the materialistic hypothesis of psychic layers or strata as well as to the spatial dimensions which this hypothesis attributes to such phenomena as thinking, reasoning, and judging. The foreconscious or preconscious has but little impact in Freudian psychoanalysis.

THE REPRESSED UNCONSCIOUS

On this crucial topic, which, in the doctrine of Freud, is the counterpart of repression, the following thoughts suggest themselves.

a) *The unconscious, as explained by Freud, should rather be called the repressed unconscious.*

It seems best, we think, not to treat the unconscious and repression as two psychic realities, but rather as facets or aspects of a combination which should be called the repressed unconscious. Neither the unconscious nor repression by itself gives a complete picture. One without the other is unintelligible. Repression and the unconscious are as closely combined as are a man and his shadow at midday. The repressive mechanism of Freud's school needs the unconscious into which all unknowingly it consigns the disturbing complex. Were there no unconscious there would be no place into which the complex could be repressed; there would be no goal for the repressive activity. Some authors, while treating this matter, discuss variously either repression or the unconscious while others speak of the complete unit as the repressed unconscious. This latter procedure seems preferable to us.

b) *The repressed unconscious, in the Freudian sense, is an unavailing materialistic attempt to explain psychic life and activities.*

The repressed unconscious is the pathetic approach of a monist to a dualistic reality, of a materialist to a reality composed of a body and a soul, of a "scientist" to a psychic phenomenon. The repressed unconscious of Freudian psychoanalysis is completely and entirely based on a materialistic concept of man's psychic life. It has been established in psychology that man's soul, his mind, will, judgment, principles, ideas, and conflicts are without extension and are simple and spiritual. They may not therefore be subjected to the spatial limitations imposed by the threefold division of the psychic life described by Freud. Man's psychic life is immaterial and inextended. The framework of mental topography as presented by Freud is crassly materialistic and spatially extended.

c) *The repressed unconscious of Freud cannot account for motivation that leads to activity.*

It is impossible that an unconscious of the type referred to by Freud can account for the motivation required for conduct since the repressed unconscious and its meaning or significance are totally removed from awareness. That Freud intended to be so understood seems evident from the obvious literal meaning to be attached to the various quo-

tations we have given from Freud's writings in the course of this chapter. That he maintained that the content of the repressed unconscious totally eludes the individual seems to be the only decision which can be reached by an impartial criticism of the works of Freud. "Psychoanalysis regarded everything mental as being in the first instance unconscious."⁸⁶ Again we were told that:

The unconscious is the true psychic reality; in its inner nature it is just as much unknown to us as the reality of the external world, and it is just as imperfectly communicated to us by the data of consciousness as is the external world by the reports of our sense-organs.⁸⁷

That the content or meaning of the repressed unconscious is unknown to the individual is the manner in which Freud's works have been evaluated and interpreted by the most sympathetic members of his own household.

Freud maintained that the repressed unconscious, with its dynamic power, begets symptoms and allures and incites and even determines the individual to think and feel and act as he does. Yet the unconscious conflict is in no way known to the individual. Though man acts because of stimulation exerted by the repressed unconscious, he is, Freud said, totally unaware of the existence or nature or power of the hidden dynamo that propels him to activity. He does not know the source of the determining stimulation to activity; he is coerced to act and does not know why. Let us recall that there is no free will in Freud's doctrine.

Now such a mode of reasoning about psychic life and mental activity is not only "scientific," materialistic, and deterministic but is utterly without psychological foundation. It is psychologically evident and accepted by everyone except the materialists that motives enticing to action must somehow be recognized by the individual, if not focally, at least vaguely or marginally, before he can rationally proceed to activity. A rational being does not tend toward an unknown goal. The motive for activity comes before the activity itself. This is basic in the very nature of man's psychic life and psychic activity. Knowledge is invariably prior to action. The good possessed by an object must be known to man before he tends toward it. The conclusions that all beings proceed to activity because of some goal or motive (*omne agens agit propter finem*) and that nothing is willed unless it be previously known (*nihil volitum nisi praecognitum*) are axiomatic and of universal validity. But the content of the Freudian

unconscious is known to the individual neither directly nor marginally. It is said to be *totally* removed from awareness and is beyond ordinary recall. Now what is totally removed from awareness and unknown to the individual can in no sense afford motivation for conduct. Hence, we repeat, the repressed unconscious of Freud cannot account for motivation that leads to activity.

d) The repressed unconscious of Freud is deterministic and therefore destructive of human freedom.

The repressed unconscious of Freud has the added blemish of being totally deterministic. According to his adherents it coerces men to think and to display symptoms. Human conduct is governed and necessarily so, they assert, by the dynamic influence of this hidden, unknown, and totally forgotten power in the unconscious. Free will is thus denied and man is driven to action by an unknown, unrecognized force. This occurs, they state, in spite of the fact that the average patient, during his so-called determined and coerced activity, has and gives the impression that he knows why he is acting and thinks that he is acting freely.

Freud expressly denied the freedom of the will in several parts of his works. For example, he said: "... you have an illusion of a psychic freedom within you which you do not want to give up. I regret to say that on this point I find myself in sharpest opposition to your views."⁸⁸

e) The repressed unconscious though proposed merely as an hypothesis is even as such totally unsatisfactory.

"An hypothesis is a proposition whose truth has not been demonstrated, but which for the time being is assumed as true, because it seems to assign a satisfactory cause of known phenomena."⁸⁹ The hypothesis of the repressed unconscious of Freud does not do this. The reason is that the unconscious or repressed unconscious cannot explain how any type of psychic activity, normal, neurotic, or psychotic, is initiated, motivated, or caused. All voluntary activity needs a motive at least vaguely or marginally recognized to initiate it. Freud maintained that the content of the repressed unconscious initiated, and caused, neurotic and psychotic symptoms in the individual. At the same time he asserted that, true to its name, the repressed unconscious was totally unknown to the individual and was beyond ordinary recall. It was, therefore, recognized neither directly nor marginally. It should be recalled that for Freud "the unconscious is the true psychic reality; in its inner nature it is just as much unknown to us as the reality of the external world."

We do not believe the hypothesis of the repressed unconscious can account for motivation to conduct, normal or abnormal, in the psychic life of the individual nor can it lead to the production of symptoms.

It would, therefore, seem that the Freudian hypothesis of the repressed unconscious and of its causality in producing symptoms is, judged by the principles of elementary psychology, without foundation. We must, therefore, seek some other explanation for man's symptoms and psychic life in general.

Concerning an hypothesis, it may be observed that neither the proposition itself nor any legitimate inference from it should contradict any established truth. The hypothesis of the repressed unconscious contradicts the established truth that an unconscious motive can give rise to no psychic activity.

f) The unconscious of Freud is based on a false concept of man's psychic nature.

Freud maintained the existence of hereditary race images or race memories or innate ideas. He identified these race memories (engrams) with instincts. It has however been demonstrated beyond question psychologically that man has no innate ideas or race images. His entire knowledge comes to him through his senses. His ideas are obtained by the abstractive activity of the intellect. Race experiences are transmitted, if at all, not by organic but by social inheritance. Man has innate urges or instincts, but not race images or engrams.

SUMMARY OF DISCUSSION OF THE REPRESSED UNCONSCIOUS OF FREUD

a) The unconscious, as explained by Freud, should rather be called the repressed unconscious.

b) The repressed unconscious, in the Freudian sense, is a materialistic attempt to explain psychic life and activities.

c) The repressed unconscious of Freud cannot account for motivation that leads to activity.

d) The repressed unconscious of Freud is deterministic and therefore destructive of human freedom.

e) The repressed unconscious, though proposed merely as an hypothesis, is even as such an unsatisfactory concept.

f) The unconscious of Freud is based on a false concept of man's psychic nature.

In light of the above reasons, we cannot accept the principles underlying the repressed unconscious of Freud.

VARIOUS AUTHORS ON THE REPRESSED UNCONSCIOUS

Not only is the notion of the repressed unconscious of Freud basically unsound psychologically, but it is also contrary to the teachings of many contemporary writers.

1. Mortimer Adler states:

The pain of failure may cause the will to withdraw from its conflict with the passions. Withdrawal becomes repression when the will moves the reason not to consider the object to which the passions tend.

Repression must, therefore, be defined as a habit of the will not to consider a certain idea, and the idea which is the content of this habit belongs to the repressed unconscious in distinction from the preconscious memory.

The permanence of repression can be accounted for only as a habit of the will not to consider certain ideas.

Repressed ideas are those which we will not consider but they remain in the memory, nevertheless, and have operative tendencies.⁸⁰

Adler, therefore, holds practically the same judgment on the unconscious that we propose, that repression is marginal.

2. Sadler defines the unconscious as "the more dormant and more deeply placed engrams or reaction patterns, together with types of functional behavior which go on in the subconscious, but which, at any moment, are not a part of the focused consciousness."⁸¹

He also asserts that: "The academic psychologists are undoubtedly right when they insist that 'there is no such thing as the subconscious' technically speaking; human consciousness is a unified experience, a single and continuous domain of feeling, thinking, willing, and acting." Sadler further calls the subconscious "more or less a figure of speech," and he refers to it again as "marginal consciousness." He does not believe in unrecallable repressed complexes since he describes ideas which were buried for two or three decades and were still brought to light.

3. Speaking of the existence of the Freudian unconscious, of that repressed psychic energy endowed with dynamic properties, McBride remarks: "We must admit that this proposition does not seem to have any support sufficient to justify its acceptance as a premise. Indeed, it is so improbable that it is difficult to account for its adoption by various writers on psychoanalysis on any other assumption than that it is necessary in order to make their position tenable."⁸²

He again states, "To the ordinary man a mind without consciousness seems a perfect contradiction in terms. . . ." ⁹³

Discussing the viewpoint of those who have uncritically accepted the hypothesis of Freud, McBride observes: "They seem not to have realized that his conception of the unconscious is a thing by itself and evolved by himself, that it is purely an hypothesis, and that it is not supported by fact or probability but has been merely assumed." ⁹⁴

McBride continues, "We are in no sense justified in assuming an unconscious mentality, a dynamic psyche and the rest of the psycho-analytical postulates." ⁹⁵ He criticizes the uncritical acceptance by medical men of the Freudian principles and he adds that "to build a system of treatment upon a foundation so insecure is a breach of all the scientific rules which have hitherto guided careful physicians in suggesting novel methods." ⁹⁶

4. Olkon has the following to say on the definition of the unconscious:

These definitions come from a varied group of authors and represent the opinions of the clergy, psychologists, metaphysicians, psychoanalysts, novelists, lay writers, journalists, sociologists, political economists, the lay press and even mathematicians. No two of them agreed on the fundamental concept as to the nature of the unconscious. Anecdotally, it seems they were all looking for the black cat in the dark cellar which was not there. It is interesting that all of these learned men are reaching out for the unknown, perhaps due to the apparently inherent desire to be master over all thoughts and the mysterious as well. ⁹⁷

Olkon obviously is not overimpressed by the notion of the unconscious mind.

5. Gruender, psychologically discussing the subconscious processes, says that "they involve a *dim awareness* of some object of suppressed hope, desire, fear, and the like." ⁹⁸ This, we believe, is the only explanation that can reasonably be given.

6. Jelliffe and White evidently maintain marginal repression. One of their comments is as follows:

It will probably occur to many to wonder how it is that one can expect to find memories reaching back to years sufficiently well preserved to be helpful. As a matter of fact the memories of all repressed experiences are perfectly clear no matter how old. The explanation for this is that being repressed they are dissociated from the every-day events of life, they are kept in their original form, they have not been subjected to the attrition and amalgamation with the intricacies of associational life. They do not fade out by this process of absorption as do the memories of

indifferent events, but remain where ever after they may be brought to light by analysis and used as helps for cure.⁹⁹

These authors do not give the impression that the memories they refer to are beyond recall.

7. The very basis of Freud's contention, that repression in his sense of the word is a prerequisite for a mental disorder and for the formation of a symptom, is denied by Henderson and Gillespie: "The onset of the symptom may not always involve repression but may be only a mental conflict without repression."¹⁰⁰

8. Fromm-Reichmann considers the repressed unconsciousness as that for which the patient possesses "reduced awareness."¹⁰¹ In the same book the presence of "marginal thoughts" is accepted and their influence on the psychic life of the individual is appreciated.¹⁰²

9. Ford, in his essay on *Depth Psychology, Morality and Alcoholism*, concludes as to the merits of Depth Psychology as follows:

One can assemble, therefore, an impressive list of names of professional psychologists and psychiatrists who reject or doubt Depth Psychology at least in its fundamental concepts of the Freudian unconscious and the unconscious motivations which are supposed to pervade the conscious life of normal people. Sachs names the following American authors: Dana, Peterson, Kennedy, Walsh, Mills, Hollingsworth, Jastrow, Burnham, Franklin, and MacDougall. To this list may be added Sachs himself, Allport, Salter, Allers, O'Brien, Williams, Freyhan, Johnson, Blanchette, Meyer, Kanner, and Myerson. In Europe we have the names of Bumke, Shulte, Hoche, Herbart, Kronfeld, Strauss, Henderson, Lavastine, Mann, Dercum, Willwoll, Strumpell, Thurn and Lindworsky. Not all of these names are of equal weight. Not all are opposed to Freudianism in toto. But it can be fairly stated that they all reject or are seriously skeptical about the dynamic unconscious as conceived by Depth Psychology.¹⁰³

THE CONCEPT OF MARGINAL CONSCIOUSNESS

As we have previously stated, we accept fully the idea of repression and of unconscious factors in the psychic life. We do not, however, believe that the Repressed Unconscious of Freud is an adequate or acceptable explanation of these entities. The concept of a Marginal Consciousness not only explains more clearly the facts of experience in regard to repression but offers an acceptable theory of motivation. According to this idea consciousness varies from a focal or central consciousness, that is, those ideas of which we are here and now

thinking, to a gradually decreasing awareness on the periphery of consciousness, and finally, to a point of relative, though not total, unawareness (unconscious).

Genetics of Marginal Consciousness

Many of our daily experiences affect us in such an emotionally unpleasant manner that their continued memory or recollection in consciousness is as unacceptable as was the original traumatic experience. Because of their disturbing influence, such recollections and memories are sidetracked and ignored and they therefore recede from focal clarity to a psychic condition or state of "decreased awareness." This process may be called marginal repression and the repressed conflict may be said to be marginally conscious. On being marginally repressed, such memories or conflicts do not cease to be part of our total psychic life. They continue to be obscurely attended to and, in proportion to their emotional content, they influence obscurely but nevertheless potently the conscious life of the individual.

It is as if some buoyant material were pushed below the level of the water; it must be held there by a force greater than itself or it will return to the surface. The greater the emotional value of the repressed material, the more likely it is to try to return to consciousness, and the greater will be the resistance to its return if it were of unpleasant content.

When repression occurs, therefore, the existence of the conflict is to a degree ignored. The individual, in his attempt to escape the painful phases of the conflict, directs his attention to an agreeable or at least to a less undesirable object. Such an individual therefore attempts to escape the conflict and, by looking in another direction, to ignore the disturbing issue.

It might be said that repression is an unthinking, indirect rejection of the conflict. Repression is therefore achieved not so much by an overt formal act of the will rejecting the conflict as an explicit act of the will directing the mind to consider some other object and by so doing to evict the unpleasant conflict from focal consciousness.

Yet, though the conflict be driven from focal to marginal consciousness (repressed), it is not totally forgotten by the individual. It is marginally recognized and dimly adverted to. In such instances, the individual attends more to his perturbed feelings, however, than he does to the repressed conflict which caused them. The outraged feelings, the effects, are in focal attention and the repressed conflict, the

cause, is in marginal awareness (unconscious). Besides that, the repressed conflict is psychically distasteful and is therefore ignored, shunned, and spurned.

Hence it is that through lack of attention given to the repressed conflict, it may for a long time be considered as forgotten, nonexistent, and unconscious. It is, however, present in the haze and obscurity of marginal consciousness. The marginally repressed conflict is never totally forgotten though it is largely ignored.

1. *The Marginally Repressed Conflict Is Dynamic:* Nor is the conflict repressed to marginal consciousness totally inactivated or subdued. On the contrary, it retains its dynamic disconcerting power, though because of lack of attention to it, its causal influence may be somewhat obscured. The repressed conflict, though but vaguely and dimly attended to, motivates, initiates, and stimulates the same emotions of fear, worry, anxiety, inferiority, and hypochondriasis that it did prior to its being repressed.

2. *Marginal Awareness Suffices for Motivation:* Knowledge and motives need not be in focal awareness to incite to activity or to attract or repel the will. It is universally granted and even experimentally established that the marginal presence of motives suffices to allure to activity. Implicit knowledge as well as habits of mind entice and motivate men to varied types of activity. This is obvious since much of our conduct is not the result of motives that exist in clear focal consciousness. The influence of attitudes on conduct is well known.

3. *The Marginally Repressed Complex Resembles Habitual Memory:* The dynamic influence of the complex repressed to marginal consciousness may in several respects be compared to the motivation and causality exercised by habitual memory. It is not easy to recall the rules and principles underlying Latin, Greek, algebra, and logic studied many years ago. Efforts of varying degrees of intensity will, however, succeed in recapturing the fading details of such subjects. Though not in focal consciousness they are not totally beyond recall. Such a type of knowledge does, however, underlie and motivate our conduct. We may write Latin and Greek correctly, solve algebraic problems, and even reason logically without specifically adverting to the underlying principles. Knowledge of this type is, however, in marginal and not in focal consciousness, is dynamic and is recallable. Principles are retained in dim awareness and assist in shaping conduct. What has been said of the memory is also true, we believe, of the unconscious.

4. *The Matter in Brief*: The marginally repressed conflict may be considered unconscious, though not in the Freudian sense of being totally removed from awareness. The marginal repression of a conflict begets its decreased awareness or its obscure marginal perception or recognition. The conflict, though thus repressed, is still dynamic and influences conduct. The marginally repressed experience may, however, be recalled and resolved by relatively simple though efficacious methods which require neither the time nor the expense nor the scaffolding connected with Freudian psychoanalysis.

MARGINAL CONSCIOUSNESS AFFORDS AMPLE MOTIVATION FOR CONDUCT

It has been observed that motivation for conduct need not be too clear, but on the other hand to be true motivation it cannot be totally unconscious. There can be no doubt that the repressed conflict does motivate to activity since men do act under its influence. Yet the conflict is not, nor need it be, in focal awareness. The repressed conflict is not, therefore, totally removed from awareness, nor yet is it in focal consciousness. This type of knowledge, marginal awareness, is sufficient to motivate for activity and avoids all the psychological pitfalls connected with the repressed unconscious of Freud.

We may, therefore, conclude that conduct needs motivation. Men act with a purpose in view. Were the content of the repressed complex totally split off from consciousness and beyond recall it could not function as a motive which induces one to activity. A motive that is totally unconscious cannot influence man's conduct. Nor is conduct always or even for the most part the result of explicit motivation present in focal consciousness. It follows, therefore, that sufficient motivation for conduct comes from the complex repressed to marginal consciousness. For that reason, among many others, we believe that the repressed complex is not totally outside the range of consciousness. It is in marginal awareness and influences one's psychic life. Marginal awareness entices or allures to activity, but does not determine the individual to it. *Marginal awareness accounts for human conduct.*

The repressed complex, though thus repressed, is not rejected beyond recall. In fact, the repressed unconscious in this sense of marginal awareness suffices to motivate and influence the activity of the individual and directly so, even though obscurely.

"Repressed ideas are those which we will not consider but they remain in the memory nevertheless and have operative tendencies."

We shall use the words marginal consciousness and unconscious, as above explained, as synonyms. Such procedure is in harmony with rational and experimental psychology. It supplies an adequate basis for dynamic therapy.

SOLUTION OF CONFLICTS

Harassing conflicts, depressing emotions, perturbing feelings are psychic realities men daily encounter. Such experiences, irrespective of their cause, have in common the fact that they are invested with a profoundly unpleasant affect. This unpleasant affect the individual has no desire to tolerate. The question for him now is how to meet the conflict which causes him this psychic unrest. The problem, he realizes, can be met in one of the three following ways:

1. *By the way of reality.* This means that he resolves the conflict by the light of reason and thus disposes of it satisfactorily. This type of solution of a conflict leaves no perturbing psychic residuals, but such an intellectual solution is infrequently achieved.

2. *By way of suppression.* The irritating conflict is voluntarily rejected and kept under voluntary surveillance though unsolved as to its constitutive factors.

3. *By way of repression.* In this case the individual averts his gaze from the disturbing complex, ignores it, and directs his attention to a pleasant, or at least to a less unpleasant, situation or reality. In his perturbed condition he thinks it is best thus to avert his psychic gaze from his conflict and attempt to ignore or forget it and look somewhere else for comfort. This method of meeting conflicts may later on become so habitual to him as to be considered almost automatic or reflex.

Wishful thinking and autosuggestion may often largely supplant reason. Displacement or other mental mechanisms become active and the original repressed complex may be so ignored as to be largely forgotten. *In such cases the repressed complex may be said to be in marginal consciousness or marginal awareness or to be unconscious.*

We have briefly presented our approach to the unconscious. We discussed the genetics of marginal consciousness. We saw:

1. That the marginally repressed conflict is dynamic,
2. That marginal awareness suffices for motivation,
3. That the marginally repressed complex resembles habitual memory,
4. That the technique of free association presumes nothing deeper than marginal repression.

We have presented the opinions of various authors on the repressed unconscious, and have come to the realization that they are in substantial agreement with our opinion.

From the foregoing, therefore, it is clear that from psychological arguments and from references to authority, the repressed unconscious of Freud is not an acceptable concept. Repression may and does exist as well as the unconscious, but in a sense quite different from that in which Freud employs them.

In concluding these remarks we are of the opinion that our arguments in favor of marginal repression merit acceptance. All psychiatric problems can be thus explained. The repression to marginal consciousness is in harmony with man's life and nature. It harmonizes with the data of Scholastic and experimental psychology. It is strictly dualistic.

Differentials

Marginal Repression of Cavanagh and McGoldrick and the Repressed Unconscious of Freudian Psychoanalysis. Marginal Repression differs in various respects from Repressed Unconscious. The following items may be cited as examples of such differentials:

	Repressed Unconscious of Freudian Psychoanalysis	Marginal Repression of Cavanagh and McGoldrick
1. Presuppositions	No God in the true sense, no soul or immortality, no mind, no free will; false basis for norms of morality; false concept of guilt; existence and activity of Libido; no true instincts; infantile sexuality; incestuous urges, Oedipus Complex; mutilation threat that begot the fear which in turn effected repression of the Freudian incestuous urge.	God's existence and providence over His creatures; man composed of body and immortal soul with mind and will; scholastic explanation of instinct, morality, religion, emotions, needs, conflicts, and their inadequate solution resulting in frustration, depression, and marginal repression of irritating situations or experiences.
2. Content	The primary object repressed is the Oedipus Complex.	Any traumatic happening not adequately resolved and assimilated.
3. Relation to awareness	According to psychoanalysis the Oedipus Complex though highly dynamic is totally removed from awareness; though, thus removed from awareness, it still entices and even determines the individual to activity.	Always dimly or vaguely in evidence. Because, however, of its emotionally unacceptable elements it continues to receive diminished or no attention.
4. Method of recall	The uncovering and recall of the Repressed Unconscious of Freud requires special techniques such as free association.	The Marginally Repressed Unconscious may be recalled by regular psychological association, by the formal explicit direction of attention upon the traumatic repressed; minimal use of free association.

FOOTNOTES

1. Robert W. White, *The Abnormal Personality* (New York: Ronald Press Co., 1948), p. 30.

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3. *Ibid.*, p. 29.
4. Sigmund Freud, *An Autobiographical Study*, trans. by James Strackey, 2 ed. (London: Hogarth Press and the Institute of Psychoanalysis, 1946), p. 34.
5. *Ibid.*, p. 34.
6. White, *op. cit.*, p. 32.
7. *Ibid.*, p. 34.
8. Freud, *op. cit.*, p. 40.
9. *Ibid.*, p. 41.
10. *Ibid.*, p. 46.
11. *Ibid.*, p. 96.
12. White, *op. cit.*, p. 34.
13. Freud, *op. cit.*, p. 34.
14. *Ibid.*, p. 75.
15. *Ibid.*, p. 53.
16. *Ibid.*, p. 53.
17. Sigmund Freud, *New Introductory Lectures on Psycho-Analysis*, trans. by W. J. H. Sprott (New York: W. W. Norton Co., Inc., 1933), p. 101.
18. Sigmund Freud, *The Ego and The Id*, trans. by Joan Riviere (London: L. and Virginia Woolf at the Hogarth Press and the Institute of Psychoanalysis, 1927), p. 52.
19. Freud, *op. cit.*, p. 110.
20. Dom Thomas Verner Moore, *The Nature and Treatment of Mental Disorders* (New York: Grune & Stratton, 1943), p. 34.
21. Freud, *The Ego and The Id*, p. 52.
22. *Ibid.*
23. Freud, *New Introductory Lectures on Psycho-Analysis*, p. 104.
24. *Ibid.*, p. 107.
25. Freud, *The Ego and The Id*, p. 30.
26. Abraham A. Brill, *Lectures on Psychoanalytical Psychiatry* (New York: A. A. Knopf, 1947), p. 58.
27. Sigmund Freud, *The Collected Papers*, 3 ed. (New York, London: Published by Leonard Wolf at the Hogarth Press and the Institute of Psychoanalysis, 1946), Vol. IV, p. 127.
28. Freud, *The Ego and The Id*, p. 15.
29. Freud, *New Introductory Lectures on Psycho-Analysis*, p. 106.
30. Freud, *The Ego and The Id*, p. 29.
31. *Ibid.*, p. 28.
32. Freud, *New Introductory Lectures on Psycho-Analysis*, p. 106.
33. *Ibid.*, p. 107.
34. Joseph Donceel, "Second Thoughts on Freud," *Thought*, Vol. XXIV, No. 94.
35. Freud, *New Introductory Lectures on Psycho-Analysis*, p. 97.
36. *Ibid.*, p. 97.
37. *Ibid.*, p. 82.
38. *Ibid.*, p. 110.
39. *Ibid.*, p. 87.
40. *Ibid.*, p. 85.
41. *Ibid.*, p. 86.
42. *Ibid.*, p. 95.
43. *Ibid.*, p. 93.
44. *Ibid.*, p. 107.
45. Freud, *The Collected Papers*, IV, p. 106.
46. *Ibid.*, p. 105.

47. *Ibid.*, p. 107.
48. Freud, *The Ego and The Id*, p. 20.
49. Freud, *New Introductory Lectures on Psycho-Analysis*, p. 102.
50. Freud, *The Ego and The Id*, p. 20.
51. *Ibid.*, p. 11.
52. *Ibid.*, p. 10.
53. *Ibid.*, p. 12.
54. Freud, *op. cit.*, p. 101.
55. Freud, *The Ego and The Id*, p. 12.
56. Sigmund Freud, *A General Introduction to Psychoanalysis*, trans. by G. Stanley Hall (New York: Boni and Liveright, 1926), p. 253.
57. *Ibid.*, p. 295.
58. *Ibid.*, p. 188.
59. Dom Thomas Verner Moore, *The Nature and Treatment of Mental Disorders*, p. 35.
60. Freud, *A General Introduction to Psychoanalysis*, p. 259.
61. Freud, *New Introductory Lectures on Psycho-Analysis*, p. 82.
62. Freud, *op. cit.*, p. 259.
63. Freud, *A General Introduction to Psychoanalysis*, p. 299.
64. *Ibid.*, p. 104.
65. *Ibid.*, p. 105.
66. Freud, *The Ego and The Id*, p. 12.
67. *Ibid.*, p. 13.
68. Roland Dalbiez, *Psychoanalytical Method and the Doctrine of Freud*, trans. from French by T. F. Lindsay (London, New York: Longmans, Green & Co., 1941), Vol. II, p. 41.
69. Freud, *Autobiographical Study*, p. 53.
70. Freud, *The Ego and The Id*, p. 12.
71. *Ibid.*, p. 16.
72. Freud, *A General Introduction to Psychoanalysis*, p. 247.
73. *Ibid.*, p. 247.
74. Freud, *An Autobiographical Study*, p. 79.
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76. Freud, *A General Introduction to Psychoanalysis*, p. 95.
77. Smith Ely Jelliffe and William A. White, *Diseases of the Nervous System* (Philadelphia: Lea and Febiger, 1929), p. 147.
78. Freud, *op. cit.*, p. 247.
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80. Freud, *The Ego and The Id*, p. 52.
81. *Ibid.*
82. *Ibid.*
83. *Ibid.*
84. *Ibid.*
85. Gordon W. Allport, *Personality, A Psychological Interpretation* (New York: H. Holt & Co., 1938), p. 218.
86. Freud, *An Autobiographical Study*, p. 55.
87. Sigmund Freud, *Interpretation of Dreams*, trans. by A. A. Brill, comp. rev. ed. (London: G. Allen & Unwin, Ltd.; New York: The Macmillan Co., 1937), p. 562.
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89. Michael W. Shallo, *Lessons in Scholastic Philosophy* (Philadelphia: P. Reilly, 1915), p. 83.
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91. William Sadler, *Theory and Practice of Psychiatry* (St. Louis: The C. V. Mosby Co., 1936), p. 88.
92. P. McBride, *Psychoanalysts Analyzed* (London: William Heinemann, 1924), p. 78.
93. *Ibid.*
94. *Ibid.*
95. *Ibid.*
96. *Ibid.*
97. David M. Olkon, *Essentials of Neuro-psychiatry* (Philadelphia: Lea and Febiger, 1945), p. 35.
98. Hubert Gruender, *Experimental Psychology* (Milwaukee: The Bruce Publishing Co., 1932), p. 6.
99. Jelliffe and White, *Diseases of the Nervous System*, p. 134.
100. David K. Henderson and R. D. Gillespie, *A Textbook of Psychiatry*, 6 ed. (New York: Oxford University Press, 1946), p. 174.
101. Frieda Fromm-Reichmann, *Principles of Intensive Psychotherapy* (Chicago: University of Chicago Press, 1950), p. xiv.
102. *Ibid.*, p. 71 sqq.
103. John C. Ford, S.J., *Depth Psychology, Morality and Alcoholism* (Weston, Mass.: Weston College, 1951), pp. 31-32.

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THE ATTITUDE OF THE HOLY SEE TOWARD PANSEXUALISM OF FREUD

One of the most controversial points in regard to Freudian psychoanalysis is his theory on sex. The proper moral attitude toward this subject was discussed by the Holy Father in an address to the First International Congress on the Histopathology of the Nervous System on September 14, 1952, in which he discussed "The Moral Limits of Medical Research and Treatment." The *L'Osservatore Romano* of September 21, 1952, in an editorial interpreting this address stated: "In his profound discourse made on the occasion, The Holy Father enumerates three principles which, from the moral point of view, can justify new procedures and new tests and methods of research and medical treatment: namely, the interests of science, the individual interests of the sick person, and the interests of the community (the 'common good'). And then he examines, point by point, whether these three principles are valid without restriction or only in a limited way, that is, within limits determined by the ethical order."

Discussing the utility and advantages of the individual the Holy Father concerned himself, among other things, and in a reproving manner, with the "pansexual method of a certain school of psychoanalysis." Regarding this particular species of psychoanalysis, His Holiness expresses Himself in these terms:

In order to rid himself of repression, inhibitions or psychic complexes man is not free to arouse in himself for therapeutic purposes each and every appetite of a sexual order which is being excited or has been excited in his being, appetites whose impure waves flood his unconscious or subconscious mind. He cannot make them the object of his thoughts and fully conscious desires with all the shocks and repercussions such a process entails. For a man and a Christian there is a law of integrity and personal purity, of self-respect, forbidding him to plunge so deeply into the world of sexual suggestions and tendencies. Here the medical and psychotherapeutic interests of the patient find a moral limit.

It is not proved — it is, in fact, incorrect — to state that the pansexual method of a certain school of psychoanalysis is an indispensable integrating part of all psychotherapy which is serious and worthy of the

name. It is not proved that past neglect of this method has caused grave psychic damage, errors in doctrine and application in education, in psychotherapy and still less in pastoral practice. It is not proved that it is urgent to fill this gap and to initiate all those interested in psychic questions in its key ideas and even, if necessary, in the practical application of this technique of sexuality.

We speak this way because today these assertions are too often made with apodictic assurance. Where instincts are concerned it would be better to pay more attention to indirect treatment and to the action of the conscious psyche on the whole of imaginative and affective activity. This technique avoids the deviations We have mentioned. It tends to enlighten, cure and guide; it also influences the dynamic of sexuality, on which people insist so much and which they say is to be found, or really exists, in the unconscious or subconscious.

These words of the Sovereign Pontiff offer an authoritative norm on the subject of psychoanalysis, which is so much discussed today. The Holy Father was not treating of psychoanalysis in general, nor of the various forms and techniques proposed and tried during recent decades by competent scientists, including Catholics; but he is concerned with the "pansexual method of a certain school of psychoanalysis." Nor does he even treat of the nature and the therapeutic value of this method, but of the transgression of the ethical limit committed by it. Likewise the Sovereign Pontiff does not prohibit or condemn the psychotherapeutic treatment of sexual neuroses, but he does disapprove of the amoral method of acting in the practical application of the treatment.

Moreover, it must not be forgotten that there are other psycho-analytical methods which are not infected with the vice of pansexualism; that furthermore, all the systems of psychoanalysis have in common certain principles, methods, and psychic experiments which are in no way contrary to natural ethics and Christian morality, and, therefore, are not in any way touched or reproved by the Sovereign Pontiff. Even new and more profound researches and new experiments may be made in the field of psychoanalysis, provided that the ethical order is fully observed. But in all these cases it is possible to commit errors and abuses — and they are not infrequently committed.

On the other hand, it is to be deplored that recently in some countries and nations the habitual use of the exclusively sexual method for every nervous ailment has become prevalent among not a few doctors (and even, unfortunately, some Catholics).

The latter constitute themselves as the defenders of this method on the theoretical level as well. They declare it to be licit, adducing the reason that its necessity is proved by a vast experience and by the results of this very experience. These psychoanalysts, moreover, add that priests, too, who are engaged in the care of souls or dedicated to the spiritual direction of consciences, should know the substantial elements of the theory and practice psychoanalysis as thus understood, and should convince themselves that this means cannot be neglected, although they themselves personally must not use it but make use of the help of a competent medical psychoanalyst. Otherwise there is reason to fear — they maintain — that priests may exercise their spiritual ministry with danger and harm to souls.

Unfortunately such ideas are imprudently proposed and defended in articles, books, and conferences, even by some theologians who, more concerned with the medical aspect, neglect the established norms of Christian moral teaching, again promulgated and inculcated by the Sovereign Pontiff himself.

THE SUBCONSCIOUS

Closely connected with the notion of conscious and unconscious is that of the *subconscious*. Before proceeding further we will give a brief summary of various meanings at different times attached to this term. In this way, when the word is encountered it will be apparent from the context which of its meanings apply.

In the past the term "subconscious" was more frequently used than it is at present; of late the word has largely fallen into disuse.

In the literature of the past half century at least four meanings have been assigned to the word "subconscious." These four meanings are as follows:

1. *Preconscious or Foreconscious*: In this usage the word "subconscious" means that area of the personality which is able to recall ideas or complexes that are on the verge of consciousness, notions that hang on the edge of conscious awareness. The use of subconscious in this sense can only beget confusion and obscurity and lack of precision. In this sense, subconscious should be dispensed with. This psychological state or condition is sufficiently explained by the terms "preconscious" and "foreconscious."

2. *Dim Awareness*: Consciousness has been shown to vary in intensity from focal or maximal awareness to a condition of less than focal clarity and finally fades into that of *minimal* or *marginal consciousness* which may be called the unconscious.

Thus, the intermediate twilight zone of dim or minimal awareness, between the conscious and the unconscious, is designated as the area of the subconscious. Note, however, that in this use of the term the subconscious is really a part of the conscious area of mental life because, although the awareness is dim or minimal, it is still awareness and hence conscious.

This again is frequently nothing more than the foreconscious. In either sense, that of the foreconscious or that of dim awareness, the term "subconscious" serves no useful purpose. There is no advantage in employing two words where one will do better.

3. *Subliminal Consciousness*: This meaning and use of the subconscious is derived from what is known about the nature of sensation. It is a commonplace that there is no sensation unless the stimuli reach-

ing the sense organs are of a certain strength and intensity. Yet, though many external stimuli are not of sufficient strength to beget in us a direct and immediate conscious awareness of their presence, they do reach the level of knowledge.¹ Under certain conditions it can be shown that all of us actually know more than we seem to be aware of knowing. This type of consciousness exerts its influence upon our activity although we do not realize it. These subliminal states of consciousness of which we here speak are usually designated as subconscious. As may well be seen, this type of consciousness differs little from the dim awareness of the preceding paragraph.

4. *At Times the Subconscious Is Used as a Synonym for the Term "Repressed Unconscious"*: From the above it is evident that the term "subconscious" is vague, hazy, indefinite, ambiguous, and misleading. It has been used in psychiatric literature to explain all psychic states except that of strict focal awareness.

The suggestion is therefore made that the interests of clear thinking may be best served by dispensing with the further use of the word "subconscious" and by employing only the terms "conscious" and "unconscious." The application of the basic criteria of awareness yields only these two categories. Freud himself thinks of the subconscious as "incorrect and misleading."²

SOME OTHER POINTS OF AGREEMENT AND DISAGREEMENT WITH FREUD

It is evident that Freud's teachings in psychiatry contain points of view and captions for which a psychological equivalent in a wide sense of the word has always existed in dualistic psychology. Certain aspects therefore of the Freudian system, if correctly grasped and interpreted, may be carried over to a psychiatry based on dualism. Among such common elements and material the following items seem to stand out with striking emphasis.

1. *More Acceptable Features of Freud's Teachings*

a) *Substitution of a psychological for an organic approach to the etiology of mental disorders.* This does not mean that Freud abandoned materialism. He always remained a materialist. Though in his discussion of psychic life he never ascended higher than instincts and impulses, he realized that a merely organic approach to a mental disorder was fatal and that a psychogenic explanation was essential.

b) *Certain aspects of the technique underlying psychoanalysis.* Contrary to the general impression the technique of psychoanalysis is not necessarily bound up with Freudian psychology exclusively. Freud's psychology and technique are not inseparable nor complementary. Free association (properly understood) and dream analysis (with the patient doing the analysis) can be used by anyone irrespective of his philosophical or psychological background.

It seems to us that the following citations from Donceel represent quite well the dualistic attitude toward psychoanalysis.

"There are in psychoanalysis quite a number of notions which, if well understood, can be easily integrated into a Christian conception of man. However, even these notions, as they are presented by the Freudians, too often imply materialistic connotations and must therefore be carefully examined."³

"It must be emphasized that there are valuable elements in psychoanalysis, but that they are generally connected with errors, exaggerations and distortions. The system as a whole, in its pure Freudian form, must be rejected."⁴

c) The concepts of the id, ego, and superego which Freud elaborated have their vague general equivalents in dualistic psychology.

1) The Id: The id is described by Freud as a sort of storehouse of instinctive energy, the fount of untamed drives and passions. In general it may be said that instinct could be considered the scholastic equivalent of the id. Race images should not be considered and cannot be admitted as part of instinct.

2) The Ego: The ego is the result of the combined influences of the external reality, the id, and the superego. The ego corresponds to a blend of the mind and the will. There is no will in Freud's theories.

3) The Superego: The superego with numerous restrictions is the power in Freud's doctrine which comes closest to man's conscience.

d) The censor. This is an influence which prevents ideas contrary to accepted standards from coming into consciousness. This inhibiting force may be considered to correspond to good moral habits which work almost automatically and instinctively.

e) The libido. There has been too much controversy on this topic to say that the libido and all that it entails in Freudian literature is wholly acceptable. It seems, however, only reasonable that there should be some psychic energy which is the dynamic source of all our instinctive impulses. It should be recalled, however, that Freud defined libido as follows: "I gave the name of libido to the energy of the sexual instincts and to that form of energy alone."⁵ Discussing sex, Freud informs us that "The sexual impulses are regarded as including all of those merely affectionate and friendly impulses to which usage applies the exceedingly ambiguous word 'love.'"⁶

f) Psychic determinism with the exception of free will.

According to this hypothesis, psychological phenomena, as well as physiological or physical phenomena, have definite causes, from which they follow with absolute necessity. Forgetting a name, dreaming a certain dream, experiencing a mood or an emotion, manifesting a neurotic symptom — all these are psychological phenomena . . . Philosophically there is no objection to the principle, provided we except the free decisions of our will. Only man's will, in its deliberate and conscious decisions, escapes the law of psychic determinism. Freud, of course, does not mention this exception.⁷

Freud is a rigid determinist and therefore denies the will.

2. *Objectionable Features in Freud's Theories*

The following are a few of the more objectionable features to be found in Freud's writings.

a) *Freud was in no sense a trained philosopher.* He was therefore unable to apply the principles underlying logic, psychology, ethics, or natural religion to the solution of any case. "Nowhere in his works has Freud boldly confronted the problem of problems—metaphysics."⁸

"Even when I have moved away from abstraction, I have carefully avoided all contact with philosophy proper."⁹

b) *Freud was a materialist.* Though Freud makes use of psychic terminology his underlying current of thought was invariably materialistic. The structure of the psychic life is thus interpreted in Freud's writings.

c) *Freud maintained complete human evolution.* The entire man as envisaged by Freud was the end result of evolution from more primitive forms of life.

d) *Freud overemphasized sex.* "A remarkably illogical procedure seems to be responsible for overemphasis on sex by psychoanalysts (by Freudians especially)."¹⁰

e) *Freud did not differentiate between sense and rational knowledge.*

f) *Freud denied the will and its freedom.* (*Gen. Int. to Psych.*, pp. 45 and 95.)

g) *Freud incorrectly explained the origin and the development of morals by means of the activity of the superego.*

h) *Freud rejected a rational approach to God's existence.* God's existence, Freud stated, is a self-created hypothesis designed to fill man's felt need for protection. "He creates for himself gods, of whom he is afraid, whom he seeks to propitiate, and to whom he nevertheless entrusts the task of protecting him."¹¹

i) *Freud denied the divine origin of religion.* Religion, he states, is a "mass-delusion."

... each one of us behaves in some respect like the paranoiac, substituting a wish-fulfillment for some aspect of the world which is unbearable to him, and carrying this delusion through into reality. When a large number of people make this attempt together and try to obtain assurance of happiness and protection from suffering by a delusional transformation of reality it acquires special significance. The religions of humanity, too, must be classified as mass-delusions of this kind. Needless to say, no one who shares a delusion recognizes it as such.¹²

The child's defensive reaction to his helplessness gives the characteristic features to the adult's reaction to his own sense of helplessness, i.e., the formation of religion.¹⁸

j) *The repressed unconscious.* According to Freud the conflict was totally removed from awareness, is dynamic, deterministic, and incapable of being recalled by ordinary psychological methods.

k) *Certain aspects of Freud's theory of free association* (see pp. 67-68, 282-287). We refer especially to Freud's belief that the first association which occurs to the individual is necessarily connected with the repressed complex. The reason that Freud held this is that he was a determinist. Hence he denied the freedom of the will.

"... his first association gave us the explanation" — "the first association of the dreamer must give us just what we are looking for, or at any rate lead to it" — "It can be proved that the association thus given is not a matter of choice, not indeterminate, and that it is not unconnected with what we are looking for."

Ludwig asserts that "Freud was like a man constantly looking through a too strongly cut lens. Because he passed on the glass to the rest of humanity, millions are seeing the world distorted, just as he — thus supplying themselves with wholly unnecessary headaches."¹⁴

Dalbiez concludes his discussion on the Psychoanalytical Method and the Doctrine of Freud by saying that "Psycho-analytical investigation does not explain the philosophical aspect of philosophy, the artistic aspect of art, the scientific aspect of religion. The specific nature of the spiritual values eludes the instrument of investigation which Freud's genius has created. Psycho-analysis leaves the fundamental problems of the human soul where it found them."¹⁵

SUMMARY

Some Points of Agreement and Disagreement With Freud

1. More acceptable features of Freud's teachings:
 - a) Substitution of a psychological for an organic approach to the etiology of mental disorders.
 - b) Certain aspects of the techniques underlying psychoanalysis.
 - c) The concepts of the id, ego, and superego which Freud elaborated have their vague general equivalents in dualistic psychology.

- d) The censor.
- e) The libido.
- f) Psychic determinism with the exception of free will.
- 2. Objectionable features in Freud's theories:
 - a) Freud was in no sense a trained philosopher.
 - b) Freud was a materialist.
 - c) Freud maintained complete human evolution.
 - d) Freud overemphasizes sex.
 - e) Freud does not differentiate between sense and rational knowledge.
 - f) Freud denies the will and its freedom.
 - g) Freud incorrectly explains the origin and the development of morals by means of the activity of the superego.
 - h) Freud rejects a rational approach to God's existence.
 - i) Freud denies the divine origin of religion.
 - j) The repressed unconscious.
 - k) Certain aspects of Freud's theory of free association.

FOOTNOTES

1. Dalbiez, *Psychoanalytical Method and the Doctrine of Freud*, Vol. II, pp. 1-50.
2. Freud, *Collected Papers*, Vol. IV, p. 103.
3. Donceel, "Second Thoughts on Freud," *Thought*, Vol. XXIV, No. 94, p. 468.
4. *Ibid.*, p. 483.
5. Freud, *An Autobiographical Study*, p. 63.
6. *Ibid.*, p. 68.
7. Donceel, *op. cit.*, p. 468.
8. Dalbiez, *Psychoanalytical Method and the Doctrine of Freud*, Vol. II, p. 280.
9. Freud, *An Autobiographical Study*, p. 109.
10. G. W. Allport, *Personality, A Psychological Interpretation*, p. 188.
11. Freud, *The Future of an Illusion*, trans. by W. D. Robson-Scott (London: L. and Virginia Woolf at the Hogarth Press and the Institute of Psychoanalysis, 1928), p. 42.
12. *Ibid.*
13. Freud, *A General Introduction to Psychoanalysis*, pp. 94-96.
14. Emil Ludwig, *Doctor Freud* (New York: Hellmann, Williams and Co., 1948), p. 120.
15. Dalbiez, *Psychoanalytical Method and the Doctrine of Freud*, VII, p. 325.

ETIOLOGY OF PSYCHIATRIC DISORDERS: INTELLECTUAL HABITS

Psychological Considerations

MEANINGS OF THE WORD "MIND"

The word "mind" has numerous meanings attributed to it. The *Oxford English Dictionary*¹ lists several pages of definitions and explanations of the term "mind." A few of these are as follows:

Mind: I. Memory

II. Thought, purpose, intention

III. Mental or psychical being or faculty

- (a) The seat of a person's consciousness, thoughts, volitions, and feelings; the system of cognitive and emotional phenomena and powers that constitutes the subjective being of a person; also, the incorporeal subject of the psychical faculties, the spiritual part of a human being; the soul as distinguished from the body.
- (b) In more restricted application: The cognitive or intellectual powers, as distinguished from the will and emotions.

The word "mind," or "intellect," is used here as given above in III(b).

The mind itself, or the intellect, is the immediate cause of rational knowledge. The intellect uses the images produced by the imagination as conditions for its own exercise.

ACTIVITIES OF THE MIND

The activities of the mind, or intellect, are threefold:

1. *Apprehension*, or the act of begetting an idea.
2. *Judging*, or that act by which the mind asserts the identity or the opposition of two ideas or objects.
3. *Reasoning*, or that mental process by which a conclusion is drawn from propositions already granted. The intellect develops principles, standards, and appreciates ideals. It gives man illumination and shows him the road he should follow.

KNOWLEDGE

Man, composed of a body and a principle of life, or soul, has external senses with which he contacts the external world of reality. Such powers are proximate or immediate principles of action and are called abilities, organs, capacities, or faculties. Through the external senses man secures knowledge or cognition of the outside world. The faculties that are used to secure knowledge are called cognitive powers.

Knowledge means that some type of similarity or resemblance of the object is reproduced in the knower. The act of knowledge represents the end result or product of the interaction of mind and object. Knowledge or cognition results from the psychic dynamic union of mind and object. Man's cognitive powers have the capacity of being able to detect outside realities and of producing a resemblance of them in themselves. Mind and object unite and their interaction begets an act of knowledge.

Knowledge is of two types: (1) sensory and (2) rational. *Sensory knowledge*, as has been stated, is that secured through the external and internal senses and represents the object as modified by its properties. It represents, for instance, a particular tree with its branches, leaves, and color.

Rational knowledge, on the contrary, is the abstract representation of an object, that which is signified by its essence, its constitutive notes. The rational knowledge of a triangle, for example, represents that which constitutes a triangle as such, namely, a figure enclosed by three straight lines. Rational knowledge centers on that which constitutes the essence of a thing irrespective of its particular concrete properties as they here and now exist. Thus, the sensory knowledge of a tree represents it with its height, foliage, color, and other tangible properties. The rational knowledge of a tree recognizes its "treeness," viz., that which is common to all trees of all colors, shapes, and kinds. Rational knowledge is called the idea, the notion, the concept of an object; rational knowledge is universal and may be applied in the same sense to an indefinite number of objects, however varied they may be.

THE SENTIENT SYSTEM

Traditionally man has been described as having five external senses and four internal senses. The external senses usually described are sight, hearing, taste, smell, and touch. Actually modern studies indicate that the senses acted upon by the skin, the muscles, and the

interior of the body are numerous and of great importance to psychology. The skin sense of touch, i.e., the skin sense may be subdivided into (a) touch, (b) warmth, (c) cold, and (d) pain. The internal senses are (1) common sense, (2) imagination (fancy), (3) memory, and (4) instinct.

These are all organic faculties. The organs of external sensation are quite familiar to most students, but students may fail to realize that the internal senses are also material structures.

Maher describes the internal senses as follows:

This power or group of powers constitutes those modes of mental life styled by the schoolmen the Internal Senses. The Aristotelian doctrine elaborated by the mediaeval thinkers distinguishes four such faculties, the *sensus communis*, the *vis aestimativa* or *vis cognitiva*, the imagination, and the sensuous memory. They were termed senses, or organic powers, because they operate by means of a material organ, and have for their formal objects individual, concrete, sensuous facts. The word internal marks their subjective character, and the internal situation of the physical machinery of their operations.²

It is from the sensory impressions gained through these organs that rational knowledge is obtained through the operation of the abstractive power of the intellect.

INTERNAL SENSES

*An internal sense may be defined as a perceptive faculty whose organ does not lie on the surface of the body.*³

Central sense, or *common sense*, is an internal power which perceives, unites, and classifies in the conscious beholder various impressions from the outside world. The central sense is stimulated by the external senses and co-ordinates their individual sensations into an understood composite.

Imagination is an internal cognitive power which is stimulated by the central sense and (a) preserves the images of objects perceived by the external senses, (b) recalls the images so retained, (c) creates or combines new groupings of images, (d) does not recognize the images as past or as representing past events, but relives the past as though it were present, and (e) projects the images.

There is no peculiar psychiatric significance in the imagination (a) preserving images or (b) recalling the images once derived from the world of reality. The imagination by its power of forming new

groupings of images can, however, easily have disastrous as well as beneficial effects in the life of the individual.

If moderately exercised, the imagination is helpful. Even in the most normal man there is a certain play of imagery which is harmless and even beneficial when kept under control. Daydreaming in due order and proportion may be the foundation for idealism; yet, the daydreams must be controlled.

In pathological instances, because of the harassing recollection of ill-resolved early conflicts, the individual feels the need to escape from a sense of frustration which crushes him. This frustration manifests itself in fear, anxiety, worry, and inferiority complexes. The individual frequently learns to secure temporary oblivion from his worries by going into the realms of creative imagination.

In this new combination of images, the child or man may have his every desire satisfied. Here is the realm of make-believe. The image world has in it the halo, glow, glamour, and freshness of a new terrestrial creation whence have vanished all sorrow and care. In the domain of creative images the pauper may consider himself and act as though he were a multimillionaire or Caesar or Napoleon or president of the entire universe. The man who finds the realities of contemporary civilization too exacting, too severe to be met on a rational basis and who, therefore, considers himself a failure may retreat to image land and there with the greatest ease solve the riddles of the universe. The timid weakling, the business failure in actual life, in the land of images may become the pivotal axis of Wall Street. The individual who has from his earliest days met his conflicts in a nonsatisfactory manner feels frustrated and experiences an urgent inner need for some type of substitute gratification, some escape from his haunting sense of failure. This he finds in images. *Unlike the memory, the imagination has no concept of time and thus it relives the past as though it were here and now present.* There is no past for the imagination.

In spite of what has been said, it should be remembered that the primary function of the imagination is to retain and reproduce the images received through the external senses. It is only a secondary function, but nevertheless an important one from the psychiatric standpoint, when it is considered in the sense of *fancy* or *imagination* in the sense in which we ordinarily use this term. It should be remembered that the elements of the images *reproduced in the imagination*

have actually been experienced. In the secondary sense just mentioned these images are rearranged and create new impressions.

Sense memory is an internal cognitive power of the sensory order which preserves the image, recognizes the image as past, does not organize new combinations of images, and does not project them. There is, thus, a tremendous difference between the imagination and memory. Memory does not combine images, does not project them, and *recognizes past events as past.*

Instinct is a cognitive power of the sensory order which leads unreflectingly toward activities connected with the personal or racial well-being. *It is an innate, sensuous cognitive power of animals and men which recognizes, without previous reasoning, certain factors necessary for individual and racial preservation and well-being.* It is an innate, plastic tendency toward behavior which is recognized as useful prior to experience or understanding. Instinct is innate, not acquired; is plastic, modifiable by experience whether purely sensory as in animals or at least partly rational as in man; it is, therefore, recognized as involving a cognitive element. The sense will is the appetitive power corresponding to instinct.

Instincts are of various types:

- a) *Adaptive*, which assist man to adjust himself to his surroundings;
- b) *Individualistic*, which impel man toward his personal welfare, his self-preservation;
- c) *Social*, or the natural innate tendency to seek the company of others and enjoy it.

The strongest and deepest instinct, drive, or urge in man is toward self-preservation; sex, or race preservation, is a secondary instinct or drive in the animated organism as well as in the psychic life of the individual. It is well to realize that instincts, if frustrated, may lead to serious psychic disorders. *Man innately desires self-preservation, self-realization, acceptance by the group, security, and the fulfillment of numerous kindred tendencies.*

Instinct may be classified under the following heads:

Two urges: 1. Self-Preservation

2. Race Preservation

1. Self-Preservation, which implies

- a) Physical union of body and soul
- b) Physical perfection, strength
- c) Attainment of truth by mind

- d) Attainment of good and beauty by will
- e) Social perfection or attainment
 - 1) Be accepted by group
 - 2) Be at home with groups
 - 3) Be welcomed by group
 - 4) Be secure: loved
 - 5) Be successful
 - 6) Avoid frustration
- 2. Race Preservation
 - a) Family
 - b) Love
 - c) Protection
 - d) Security: devotion

CLINICAL CONSIDERATIONS

Ego Defenses

DEFINITION:

Ego defenses, or psychic dynamisms, are essentially protective methods of judging, reasoning, and acting adopted by the individual to defend himself and/or to compensate for his subjectively, though not clearly perceived, recognized distaste or inability to face reality.

At the start, many of these ego defenses or, as we referred to these in previous writings, mental mechanisms are adopted by the individual to soften the painful realization that his conflicts have not been adequately solved. Mental mechanisms may be for the individual avenues of escape and a shield from life's problems and conflicts. For such an individual, mental mechanisms are not looked upon as at all evil. On the contrary, they are considered as possessing elements of goodness, of value, and of significance, since they bolster the ego of the individual.

CLASSIFICATION OF EGO DEFENSES

Ego defenses may conveniently be classified as follows:

- 1. Evasion
 - a) Suppression
 - b) Repression
- 2. Protection
 - a) Rationalization
 - b) Identification

- 1) Identification of ourselves with the positive traits of others
- 2) Identification of ourselves with the negative traits of others
- 3) Identification of others with our own objectionable traits
- 4) Image interchange
- c) Resistance
3. Compromise
 - a) Substitution
 - b) Sublimation
 - c) Displacement
 - d) Conversion
 - e) Symbolization
4. Compensation
 - a) Development of extremes
 - b) Projection
 - c) Introjection
5. Escape
 - a) Fantasy
 - b) Dissociation
 - c) Regression
 - d) Flight
 - 1) Into introversion
 - 2) Into extroversion
 - e) Surrender

Ego defenses must be studied because from their habitual employment arise many neurotic and psychotic manifestations. It is important to realize that the temperate use of any of these mechanisms is not pathological. Escape, for example, is not always wrong. In the presence of certain temptations we tell many young people to do exactly this. Sublimation may be a quite satisfactory solution for problems relating to celibacy. It is, therefore, important to make careful distinction between the mechanisms as an habitual way of meeting life problems and their use in selected circumstances and as specific adjuncts. The habitual use of most of these ego defenses or mental mechanisms is alone pathological. Many of the mechanisms are used at times by a vast number of people otherwise quite normal.

INDIVIDUAL MECHANISMS

1. Evasion

Types of evasion mechanisms: (a) suppression, (b) repression:

a) *Suppression* is an evasion mechanism in which the individual

consciously and voluntarily rejects the irritating conflict from focal consciousness. Those who utilize this mechanism have clearly seen the conflict but wish to discard it. By a positive effort such individuals keep the conflict out of awareness and thus gain some degree of comfort. Suppression rejects the conflict but does not solve it.

Suppression has some value in specific isolated circumstances. Certain moral conflicts of dynamic import are probably most securely met this way, when but little profit accrues from the analysis of the conflicts and much potential danger is at hand in so doing. It is also evident that the conflict is positively and voluntarily rejected.

Suppression, if more or less habitual, is undesirable in that:

- 1) It does not solve the conflict.
- 2) It indicates the individual's basic fear of unmasking the conflict.
- 3) It does not produce psychic calm since the conflict is still there, though in chains.
- 4) It begets the habit of avoiding rather than solving conflicts.

Many psychoanalysts . . . arbitrarily limit the use of the word "suppression" to the conscious exclusion of a painful idea from consciousness. . . . In the deliberate suppression of a desire, in order that it may not control action, we are conscious of the process of suppression. Nor does the suppression necessarily render us oblivious of, or insensible to, the desire or yearning. Although we may be able to suppress or control the desire voluntarily, we are quite cognizant of its imperious sway. We are keenly aware that it is at the basis of our struggle for mastery. We know perfectly well that we are waging an open battle against some inner urges that must be subjugated.⁴

b) In *repression* the individual perceives an unpleasant complex, impulse, or conflict but does not attack it and repudiate it as happens in suppression. In this case the distasteful conflict is rejected less consciously. The attention is voluntarily directed to some more pleasant or at least to some less perturbing aspect of reality. This voluntary direction of attention to some other object automatically diminishes the focal emphasis that was previously accorded to the conflict and which made it so annoying. With the direction of attention to other subjects the disturbing incident or conflict gradually recedes or fades from focal to marginal consciousness.

The conflict which is thus repressed is not totally removed from one's psychic life. It is never *completely* excluded from awareness. However, since it now exists in the haze of dim awareness and decreased perception *it may be called unconscious* though not in the

Freudian sense of the repressed unconscious. The conflict which is in marginal consciousness may be recalled by ordinary psychological methods. While in this state of dim awareness or decreased attention or marginal consciousness the conflict is still dynamic and allures and entices and urges the individual to activity but it does not force or compel or determine him to act. We use the words "marginal consciousness" and "unconscious" as synonyms. (For more details on repression see Chapter 7, "The Concept of Marginal Consciousness vs. the Repressed Unconscious of Freud.")

2. *Protection*

Types of protective mechanisms: (a) rationalization, (b) identification, (c) resistance.

a) *Rationalization* is the finding of excuses in an effort to justify that which we have already decided. It is perhaps, one of the most commonly employed of the mental mechanisms. It is unconscious personal deception. The motivation in rationalization is always in consciousness. At times, attempts at rationalization are hard for the patient to recognize, even though they are pointed out to him. The way in which rationalization is employed may be readily seen in the case of a woman who wants a fur coat although she knows that the money she would use for this purpose would be better employed for certain necessities in the home. She reasons, however, that since her husband has not had a raise in pay lately, and since they are going to meet his boss at a party in the near future, the fur coat is actually a necessity to make a good impression on the boss, so that she will be able to persuade him to raise her husband's salary.

b) *Identification* is a mechanism in which the personality and actions of others who are admired are adopted as our own. It is frequently referred to as idealization in the sense that the one admired is idealized and his characteristics adopted. In a play, or in the movies, one of the satisfactions obtained by many individuals is that of identifying themselves with the hero or heroine, and thus obtaining a few hours of vicarious pleasure. The choice of a profession frequently results from our admiration and identification with some loved member of that profession. Normally, identification in children is stronger than in adults. In their games, children actually live out the parts called for by the play acting. A certain amount of danger arises from the employment of this mechanism in children, because they may identify themselves not only with the good characteristics of the hero, but with the criminal tendencies of the villain.

Wallin says that the source of the satisfaction connected with identification is largely derived from indulgence in daydreaming. "What is the source of the satisfaction and fascination derived from indulgence in daydreaming? It can be explained, at least in part, by the well-known and widely employed mechanism of identification, or the tendency to identify ourselves with the objects and persons of our interest and admiration, the motive, perhaps, being to gain protection, security, prestige, and power and to become like those whom we respect and admire."⁵

Identification has four specific types:

- 1) Identification of ourselves with the positive traits of others.
- 2) Identification of ourselves with the negative traits of others.
- 3) Identification of others with our own objectionable traits.
- 4) Image interchange.

All of these types are sufficiently clear to need no specific discussion except image interchange.

Image Interchange. We, not uncommonly, find ourselves liking at first sight some individual of whom we had no previous knowledge. What has happened is that through a process of identification we have attributed to this individual, because of some chance resemblance or other factor, our emotional attitude toward someone whom we have previously known and liked. In this way may be explained many of our sudden and apparently irrational likes and dislikes.

We frequently identify one individual with the images taken from another person and we feel toward him as we formerly felt toward the party from whom the image was derived. Image interchange explains many of the illusions observed in neurotics and psychotics. Image interchange frequently accounts for the sudden attack made by patients on harmless, unsuspecting visitors. The visitors in some respect reminded the patient of an enemy; hence the attack.

c) Resistance, the third type of protective mechanism, refers in psychoanalytic terminology to an instinctive opposition displayed toward attempts to lay bare the unconscious. It is thought of as a manifestation of the forces which brought about repression and which are now attempting to keep this material from returning to consciousness. In this sense it may be employed by the patient in an effort not to recognize or acknowledge the mental mechanisms he is using.

3. *Compromise*

There are five types of this mechanism: (*a*) substitution, (*b*) sublimation, (*c*) displacement, (*d*) conversion, (*e*) symbolization.

a) *Substitution*, although somewhat similar to replacement, refers to the technique of improving the patient's situation by offering better, more wholesome, and more constructive ideas to take the place of those that have been harmful to him. Its purpose is to diminish, and, if possible, to eliminate tension, anxiety, and other undesirable states of mind.

b) *Sublimation* is a somewhat similar mechanism and may be defined as a mental process of directing undesirable and unhealthy drives to more hygienic, satisfactory, and acceptable types of conduct. It differs from substitution, however, in that in substitution we are attempting to replace one drive with another, whereas in sublimation the effort is merely to divert the pathological drive into a socially acceptable channel. Sublimation is usually illustrated by the example of a powerful waterfall which represents a wasteful and destructive force. If, however, some of this force is diverted through proper channels, and used to create electrical energy, the force has been "sublimated" into a useful and constructive channel. Such sublimation may be seen in a woman who, although for some reason unmarried, has a strong procreation drive which she diverts into an occupation as a teacher of preschool children.

c) *Displacement* as a mental mechanism merely means that one idea is replaced by another, as when a solid object is immersed in a glass of water and causes displacement of an equivalent amount of fluid. Such a displacement occurs when the patient accepts one idea in favor of another. This mechanism is best studied in certain compulsions. What happens here is that the affect is displaced from a severe conflict to a seemingly unrelated object. This may be easily seen in the familiar hand-washing obsession, in which the obsessional effort to wash away dirt is symbolic of an attempt to wipe away unconscious guilt.

d) *Conversion*. The emotional energy resulting from repressed conflicts may be handled in several ways by the patient. A very commonly employed method is to *convert* this energy into a somatic manifestation. In this way arise not only the classical manifestations of conversion hysteria, but also the somatic manifestations of the neuroses. When such a change takes place, it creates, in some way, a situation more favorable for the patient, whether it be the hysterical paralysis of the soldier who was thus saved from the danger of battle or the nervous indigestion of the unhappy wife who would not consider it proper to discuss her marital unhappiness with the neighbors,

but with whom she could discourse at great length about her "indigestion." The localization of conversion manifestations in the body also usually has some significance to the patient. An example of this was seen in a young Marine who, when he was exposed to great danger under battle conditions, developed a paralysis of his left hand. He was slightly wounded on the hand, which amounted to little more than a scratch. History elicited that just prior to the battle he had been masturbating with his left hand with a considerable feeling of guilt.

e) *Symbolization*. The return of material to consciousness is not usually in its original form. Such repressed concepts usually return in a changed form, which is *symbolic* of the underlying conflict or the former symptoms. Such was the case with the patient who experienced violent anxiety manifestations upon hearing "The March of the Toys." Investigation into the cause of this revealed that twenty years previously, he had undergone a very embarrassing experience in the presence of others while this composition was being played. The experience was repressed, but "The March of the Toys" remained as a symbol of it and produced similar symptoms. Symbolism is familiar to us in everyday life. It is a mental short cut in which we use an apparently irrelevant idea to represent another idea, quality, or object. The flag, for example, intrinsically consists of a few pieces of different colored cloth, but as a symbol it stands for our country and all it represents. In a similar manner the home for cats established by an old spinster is symbolic of her maternal instinct. Symbols are especially common in dreams. The manifest content of the dream is frequently symbolic of an underlying conflict which is so distasteful to the individual that even in the dream state, it is not acceptable in its true form. One girl, who had an intense hatred for her mother, dreamed frequently of the funeral of a well-liked aunt, long since dead of natural causes. In her dream, the aunt had died a violent death from beating. Her mother was never present at the funeral.

It is important, in speaking of dreams in connection with symbolism, to remember that this is not the same as the original Freudian concept of symbolism in dreams. His concept was that certain objects in a dream had definite meanings.

4. *Compensation*

There are three varieties: (a) development of extremes (reaction formation), (b) projection, (c) introjection.

No one likes to admit his shortcomings, even to himself, conse-

quently, he has a tendency to unconsciously exaggerate his abilities. This tendency is known as *compensation*. This should be distinguished from bragging in which there is a conscious exaggeration of ability. Compensation produces an individual who is likely to be much more productive of words than of deeds. Those patients who have a marked feeling of inferiority frequently overcompensate in an effort to attain security. Those who overcompensate are frequently referred to as having a "superiority complex." Actually such individuals have marked feelings of inferiority which they are attempting to overcome.

a) *Development of extremes* is a mechanism in which the patient emotionally escapes from a painful conflict by developing a trait the opposite of that which he finds too painful to face. In the presence of an unconscious feeling of extreme hostility toward a parent, for example, the patient develops the opposite feeling and shows a marked overconcern. This mechanism goes beyond the *via media* of the virtues.

b) *Projection* is a mechanism by which we externalize our thoughts and ascribe our own feelings to others. It is largely a psychotic type of mental mechanism, but may occur under other circumstances, as in the poor housekeeper who is constantly finding fault with the house-keeping of others, or the politician who so bitterly castigates his opponent for certain faults which he himself possesses. In these instances, the individuals are projecting their own feelings to others. The psychotic individual who has ideas of reference or hallucinations is employing the same mechanism. The voices of which he complains, and which so frequently speak of him in an uncomplimentary manner, are merely projections of his own internal conflicts which are too distasteful to be faced directly. He is hearing his own thoughts as if they were coming from outside of him. Such hallucinations are not always unpleasant, but they may represent wish fulfillments in which the individual hears expressions of love spoken in the voice of an absent loved one, or of a lover who has rejected him.

c) *Introjection* is a mechanism whereby an individual applies elements in the environment to himself. This is the mechanism by means of which, according to Freud, the superego develops. The child, he said, introjected (incorporated) the moral code of his parents and accepted it as his own. By this mechanism, also, an individual may identify himself with an enemy and, accepting his enemy's traits as his own, do harm to himself as a means of harming the hated one, e.g., the man or woman who commits suicide with the attitude "I will show them."

5. *Escape*

There are the following types of this mechanism: (a) fantasy; (b) dissociation; (c) regression; (d) flight (1) into introversion, (2) into extroversion; (e) surrender.

a) *Daydreaming*, or *fantasy*, is a normal characteristic of the mental life. It may be defined as the act or state of dwelling amid people or scenes created by the imagination. In the normal individual, however, such daydreaming is indulged in to a limited extent, but never to the exclusion of reality. The average person allows himself to indulge in fanciful images, to imagine adventurous deeds, or to dwell in a fanciful reverie only during moments of leisure. Indeed, ambition amounts to little more than daydreaming. When, however, the individual permits himself to derive greater pleasure from his fantasy than from reality, the process becomes distinctly abnormal. The girl, for example, who prefers to sit at home and think about the pleasures of male company when she actually has the opportunity of engaging in such social activity, is indulging in fantasy to an abnormal degree.

b) *Dissociation*. We frequently hear a patient, who is laboring under stress, make the remark that he is "going to pieces." When things get better, or when the patient feels that something must be done about the situation, he is quite likely to follow his first statement with another remark, "I must pull myself together." These remarks, made by a patient who has no knowledge of mental mechanisms, express rather perfectly the meaning of *dissociation* and *integration*. In dissociation, a patient's ideas and emotions have reached no working agreement among themselves and become, as it were, "mixed up." This expression is also commonly used by patients. Such a mechanism permits the existence in the mind, at one time, of diametrically or logically opposed ideas. It occurs, for example, in the man who, during church services on Sunday, assumes an air of piety, but who, on the other six days of the week, takes every possible opportunity to gain unfair advantage over his competitors in business. It is also an important mechanism in the development of schizophrenia where, as a result of dissociation, ideas become separated from their normal emotional components, so that the schizophrenic patient will laugh when his words indicate that he should cry. As a general rule, the basis of dissociation is that the set of ideas is determined by what the patient wishes and on the basis of what he has rationalized. Immature behavior is very common, but it is usually an evidence of a failure to develop proper mature attitudes rather than evidence of *regression*.

c) *Regression* means "moving backward." It occurs literally in certain of the psychoses and in hysteria, where the individual actually regresses from a mature to a less mature mental state. A twenty-two-year-old boy was admitted to the hospital during the war because of childish behavior and childish speech. He could only be made to behave on the ward by promises of ice-cream cones and nickels. His speech was extremely childish and he spent a great part of the day asking the ward attendants or other patients, "Where is my mommy?" Sodium pentothal narcosis relieved his amnesia and revealed that the cause of his hysterical regression was ill treatment at the hands of some of his comrades. This mechanism forms an important part of the procedure of hypnoanalysis. Under the influence of hypnotism the patient is able to regress and relive earlier experiences. In a less literal sense, the term is employed to indicate a primitive or childlike behavior of the emotionally immature individual. In this sense, it implies that the individual has gone back to a method of handling his conflict which should have been rejected as he became more mature. Examples of this are very common, as, for instance, the woman who cries when she does not get her own way; the man who kicks his automobile when it will not start; the boy who becomes angry with his radio because it will not work; the man who tears the telephone from the wall when he gets a wrong number.

d) *Flight*. Escape from reality may be sought in two other types of activity. These are (1) flight into introversion, and (2) flight into extroversion. Some part of each of these tendencies may form a normal part of the personality structure. It is only when they are present to an unusual degree that they become pathological and, when this occurs, the individual so affected is referred to as an introvert or extrovert.

The *introvert* is the individual who tends to withdraw from his conflict and to think it out. He is the thinker rather than the doer—he gets his chief pleasure from within; he is a dreamer; he is, on the surface, unemotional, unsociable, and inactive; he thinks much and does little. Introversion is a refuge and an escape from his conflicts. It is not necessarily an abnormal mechanism. Introverts are planners; they are the ones who make discoveries; they are the ones who think out new methods. Within certain limits, therefore, introversion is a useful mechanism.

The *extrovert* is the "outward" type of individual. He is the doer and not the thinker; he is the one who runs away from his problems rather than the one who thinks them out; he must constantly be "on

the go." This tendency on the part of the individual might be characterized as an unconscious flight into extroversion in an effort to escape from his conflict. He keeps going from one thing to another, attempting to keep busy so that "he will not have time to think." In the right proportions these are useful mechanisms.

e) *Surrender*. When the struggle becomes too great for the patient, reality too painful for him to face, and no acceptable solution can be found, he may completely withdraw even his inadequate defenses and *surrender*. This constitutes a complete withdrawal from reality and an escape into a psychosis.

SUMMARY

Intellectual habits of escape from conflicts and unpleasant reality are numerous. Basically they all serve the same purpose, viz., to secure greater peace of soul for the neurotic individual. It should be emphasized that the occasional use of these mechanisms is not abnormal or even undesirable. It is only their persistent use as a means of escape from life's problems which is undesirable. The most important mechanism is repression because it is at the basis of almost every neurotic disorder.

FOOTNOTES

1. *Oxford English Dictionary*, Vol. VI (1933), pp. 459-461.
2. Michael Maher, *Psychology*, 9 ed. (London, New York: Longmans, Green & Co., 1921), pp. 92-93.
3. Anthony C. Cotter, *A.B.C. of Scholastic Philosophy* (Weston, Mass.: Weston College Press, 1946), p. 157.
4. J. E. Wallin, *Personality Maladjustments and Mental Hygiene*, 2 ed. (New York: McGraw-Hill Book Co., 1947), pp. 406-407.
5. *Ibid.*, p. 360.

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ETIOLOGY OF PSYCHIATRIC DISORDERS: EMOTIONAL FACTORS

Psychological Conditions

PLEASURE AND PAIN

Pleasure is attached to the normal exercise or activity of each human power. Pleasure consists in the awareness or actual perception of well-being, joy, and satisfaction accompanying the healthy use of any faculty.

Pain is the opposite of pleasure and is occasioned by any activity contrary, either by excess or defect, to the nature and activity of the power.

The nature of pleasure and pain and the psychic and organic processes involved in begetting them is clearly explained by Dalbiez:

There are, of course, two principle theories of pleasure and pain. The so-called activist, or finalist, or biological theory emphasizes the dependence of pleasure upon the normal exercise of any vital activity; pleasure is regarded as the direct result, without passing through any intermediate cognitive stage, of the attainment of an end. The so-called intellectualist theory, on the contrary, pays most attention to the role of cognition and minimizes that of finality; pleasure is regarded as derived from the co-existence of two complementary representations. Each of these theories only takes one aspect of the situation into account: finality and knowledge are equally indispensable determinants of affective states. The development of pleasure or pain may be schematized as follows: There must first be a finality directed towards a vital end, a need. It is most important to note that this finality is a purely ontological fore-ordained condition which it would be fatal to mistake for a wish. It may be solely physiological, e.g., the living being's nutritional needs. Secondly, there must be a reality capable of gratifying this need; in our example this would be food. Thirdly, there must be physical conjunction of the need and its object; i.e., the introduction of food into the organism. Fourthly, that conjunction must be cognized; a proprioceptive sensation will inform the animal of the change effected in its body by the assimilation of food. Fifthly, this knowledge will

expand into a pleasure hardly distinguishable from it by introspection; this is the affective operation proper. The schema of pain is obtainable by directly transposing the above. We have taken an organic pleasure as an example, but a spiritual joy would serve as an equally good illustration. Let us analyze the satisfaction of the inventor. We have firstly the aptitude of the intelligence to possess truth; secondly, an intelligible object capable of supplying that aptitude; thirdly, the conjunction of the intelligence with its object in discovery; fourthly, the conscious apprehension of this intellectual enrichment; fifthly, the final perfection of affective development, i.e., the joy of knowledge.¹

NATURE OF FEELING

Feelings consist in the actual perception of pleasure or pain in the life of the individual. Feeling is the consciousness of pleasure and pain that accompanies the mental activities of judgment, reasoning, or bodily condition. Feelings consist in the awareness of the satisfactory or unsatisfactory psychic aspects of bodily states or mental processes. They are indications to the individual of the agreeable or disagreeable way in which objects stimulate him.

Depending on their source, feelings are spiritual or sensory.

Spiritual feelings are movements (neither deliberated nor free) proceeding simply from the presentation to the will by the reason of a good or an evil. The narration of a splendid achievement is enough to arouse in the hearer, before any free choice, an impulse of admiration and a desire to imitate it. Consciousness of wrong-doing excites a feeling of remorse.²

Psychic activities that are primarily intellectual may therefore have indirect influence on the body and thus beget what are known as spiritual feelings. Our organic physical reaction following or accompanying our perception of the beauty of a sunset may be cited as an example. Objects that directly stimulate the external or internal senses are the basis for sensory feelings.

One of the main obstacles to be encountered in the direction of human conduct centers around the individual's attitude toward pleasure and pain. Man for the most part recoils from pain and avoids circumstances productive of such feeling.

Man has an innate urge to enjoy pleasure to the full and to prolong and repeat the incident or activity productive of pleasure. In itself there is nothing wrong in this tendency to enjoy pleasure. It is placed there by the Creator and its temperate enjoyment cannot therefore be

evil. Pleasure should not, however, be made the sole goal of human activity.

On the other hand, reason informs man that he must subordinate pleasure to duty and that the higher values are rarely, if ever, immediately obtainable. The mind tells man all these truths but it does so in a very abstract way that appeals only to his rational powers. The mind usually does not attract the whole man while feelings offer the "pound of flesh" here and now.

Those who are led mainly by their feelings develop what one may call the "Feeling Philosophy" of life as opposed to the "Rational Philosophy" of life. They remain psychically immature and are moved to action primarily by feelings and not by reason, by impulse and not by intelligence, by pleasures and not by duty, by surrender and regression, not by aggression.

EMOTIONS

The mind is quick to realize how certain activities or situations perturb or satisfy the individual. It tells how such circumstances *affect* him. Hence, we speak of the *affective states*.

An emotion consists in the movement of the rational and sense will with subsequent bodily changes preceded by an intellectual grasp of a situation as good or bad, pleasant or unpleasant.

A blend of three elements will, therefore, always be found wherever there are emotions:

a) A mental grasp of a situation as good or bad, pleasant or unpleasant. *Intellectual cognition is a definite integral part of true human emotions.*

b) A tendency or attempt to evade the pain or to secure the good or pleasurable in the situation.

c) Bodily change varying in intensity from an almost imperceptible movement to the most profound organic perturbation found, e.g., in rage, anger, or hatred. Bodily changes are neither the essence nor a mere effect of emotion but an integral part.

Genuine emotion is always built upon or derived from rational insight and is, therefore, based on intelligence. This is evident from the nature of things and is the teaching of many psychologists.

An emotion is a reaction to an intellectual insight and not to a mere sensation.³

The presence of an intellectual element as the cause of an emotion

over and above the sensation seems to be a necessary postulate. . . . Human emotion has as its cause and its root an intellectual insight.⁴

An emotion is a simultaneous activity of both appetitive faculties—the higher and the lower—called forth by the actual knowledge of a good or evil, which as such reason alone can understand.⁵

Emotion is an affective reaction both psychic and organic to an object either perceived as external from our body, or imagined, or recalled to memory.⁶

Emotions are conscious states of excitement, brought about by the recognition of a stimulating situation, and accompanied by disturbed conditions of the whole bodily mechanism.⁷

OBJECT OF THE EMOTIONS

The object or situation which serves as the basis for the emotions may be (1) something material in the outside world, (2) something recalled by the memory, or (3) combined by the imagination. Whatever may be the basis for the emotion, the mind grasps its influence and realizes how it affects it.

Before proceeding further with the clinical features of the emotions we believe that the following discussion of the emotions which is more philosophical than clinical will help to orient the reader in the relationships which the emotions have with each other.

TYPES OF EMOTIONS:

There are two types of emotion: (1) concupiscible, (2) irascible.

1. *Concupiscible*: In this instance the intellect interprets the object or situation that it encounters as being either:

- a) Good or pleasurable in itself,
- b) Evil or painful in itself,
- c) Easily attainable, if good, or avoidable, if evil.

The object is, therefore, viewed by the mind as being agreeable or repugnant in itself and such furthermore as may be secured or avoided without difficulty.

This intellectual interpretation is followed by appetitive activity to possess the good or pleasurable and to avoid the evil or painful. Organic, glandular, or locomotor changes result from the act of the intellect and of the will, and, thus, an emotion is begotten.

There are six concupiscible emotions: love and hatred, joy and sadness, desire and aversion. These terms connote the following general impressions:

Love: tendency to possess good (no reference to difficulty).

Hatred: tendency to avoid evil (no reference to difficulty).

Joy: pleasure in enjoyment of a present good.

Sadness: sorrow because of present evil or affliction.

Desire: urge to possess good or pleasure residing in an absent object.

Aversion: tendency to avoid evil in an absent object.

2. *Irascible emotions*: In other circumstances, the intellect examines the impact of objects or situations on the individual and judges:

a) That difficulties are to be met with in

1) securing the good and in

2) avoiding the evil.

b) Despite the difficulties to be encountered, the individual will be unable to:

1) obtain certain particular types of good or

2) avoid all evil.

Appetitive and glandular activity again follow and thus are produced what are known as irascible emotions. In irascible emotions, therefore, difficulty is to be experienced in obtaining good or avoiding the evil. There are five irascible emotions: hope and despair, courage and fear, and anger. They may be considered as follows:

Hope: an absent good may be obtained though with difficulty.

Despair: an absent good is unobtainable despite difficulty to be encountered.

Courage: a threatening evil may be overcome or avoided though at a cost of difficulties.

Fear: a threatening evil is unavoidable irrespective of all efforts to escape it.

Anger: present evil afflicts the individual though he exerts arduous effort to prevent or escape it.

Concupiscible comes from the Latin *concupiscere* which means "to have a strong desire," and irascible is derived from *irasci*, "to be irritated or angry." The terms, therefore, refer to the emotions of desire (concupiscible) and the emotions of difficulty (irascible).

The following scheme may clarify the above.

The basic emotions just referred to may be variously grouped for clinical purposes. Different authors present combinations of emotions which reflect man's reactions from the point of view of his self or personal good, from that of his social interrelations, or from the aspect of man's intellectual nature. Kelly⁸ gives the following:

SCHEME OF THE EMOTIONS

The intellect interprets the object or situation as

<u>good or pleasurable</u>	or as	<u>evil or displeasurable</u>
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Concupiscible Love Joy Desire		Concupiscible Hatred Sorrow Aversion
		Irascible Hope Despair Anger Courage Fear

DEFINITIONS OF ELEVEN BASIC EMOTIONS

Concupiscible Emotions

1. *Love*: an emotion resulting from the combined acts of the intellect, which judges, with no reference to time, that an object is good and attractive, and of the will, which tends to attain it or reposes in the contemplation or possession of such goodness.
2. *Hatred*: an emotion flowing from the realization that an object or situation is evil in itself and should be avoided.
3. *Joy*: an emotion aroused by the recognition of the pleasure to be afforded through a present good.
4. *Sadness*: an emotion springing from the interpretation of the evil which affects the individual here and now.
5. *Desire*: an emotion which incites the individual to possess the good or pleasant known to exist in an absent object or situation.
6. *Aversion*: an emotion which induces an individual to avoid or shrink from the evil recognized as present in an absent object.

Irascible Emotions

1. *Hope*: an emotion begotten by the realization that an absent good, though entailing difficulty, may be obtained.
2. *Despair*: an emotion based on the consciousness that, even though difficulties are encountered, the absent good still remains unobtainable.
3. *Anger*: an emotion produced by the awareness that a present evil afflicts the individual despite his arduous efforts to escape it. The specific passion of anger may be defined as "the desire for revenge consequent on the suffering of a contemptuous injury."⁹
4. *Courage*: an emotion springing from the insight that a threatening evil may be overcome or avoided, though at the cost of toil or difficulties.
5. *Fear*: an emotion "occasioned by an impending evil that is difficult to avoid."¹⁰
 "Fear regards a future evil which surpasses the power of him that fears, so that it is irresistible."¹¹

1. *Personal emotions*: these center around the self and personal good of the individual.

- a) Produce pleasure
 - 1) self-esteem
 - 2) self-reliance
 - 3) self-love
- b) Produce pain
 - 1) pride
 - 2) self-pity
 - 3) remorse
 - 4) shame
 - 5) fear
 - 6) anger

Personal emotions tend toward excess and need repression.

2. *Social emotions*: these belong to the nonselfish and benevolent aspect of man's nature.

- a) Sympathy: feel with and share joys and sorrows of others
- b) Love; affection
- c) Friendship
- d) Patriotism
- e) Philanthropy

3. *Intellectual and aesthetic emotions*:

- a) Novelty
- b) Surprise
- c) Wonder
- d) The appreciation of the beautiful
- e) The appreciation of the sublime

The social, intellectual, and aesthetic emotions tend toward defect and need stimulation. Further information on this subject will be found in the excellent chapter by Kelly on the emotions.¹²

THE EFFECTS OF THE EMOTIONS

Much experimentation has been performed concerning the bodily change that is evidenced under the influence of the emotions. Excellent résumés of such matter are given in the works of Cannon,¹³ Weiss and English,¹⁴ and Dunbar,¹⁵ to which reference is made in the bibliography.

In general it should be remarked that the emotions themselves are far from being evil. They form a very important phase of man's total psychic equipment. Their mild and not unduly prolonged influence on the entire organism is quite beneficial. This is evident from personal experiences.

From experimental studies, it is demonstrated that the moderate exercise of emotions liberates numerous secretions of not fully understood significance which retard or stimulate the organism as needed. The emotions, however, when unduly aroused perturb the imagination, produce imbalance of secretions, and becloud reason.

The effects of the emotions may be said to be twofold: (a) primarily psychogenic, (b) psychosomatic.

a) Emotions of the *primarily psychogenic* type mainly influence the psychic powers of the individual. Emotions of the *primarily psychogenic* type, if not too intense or prolonged, are highly beneficial to the whole organism as may be witnessed in such emotions as joy, hope, courage, desire, and many others.

This type of emotion, however, if excessive and unduly prolonged, may easily become pathological. Prejudicial results of the *primarily psychogenic* type of emotional reaction may be seen in the varying manifestations of: (1) self-consciousness, (2) shyness, (3) timidity, (4) bashfulness, (5) stage fright, (6) generalized fear, (7) worry, (8) inferiority complexes, (9) hysterical amnesia, (10) confusion of all types.

Other classic examples of the pathological results of *primarily psychogenic* emotions may be observed in psychasthenia as well as in manic-depressive psychoses, schizophrenia, involutional melancholia, and paranoid reaction types.

b) *Psychosomatic effects* of emotions are primarily observable in the production of somatic, or bodily, symptoms. They affect heart, arteries, veins, capillaries, activate glands, liberate secretions, and retard or accelerate action. Some of the typical *psychosomatic* effects of emotions are observed in: (1) blushing, (2) pallor, (3) stammering, (4) dry lips, (5) tachycardia, (6) bradycardia, (7) sweating, (8) functional paralysis, (9) anorexia, (10) bulimia, (11) hives, (12) asthma, (13) gastric and duodenal ulcers, (14) spastic constipation, (15) some forms of diarrhea, (16) mucous colitis, (17) psychic impotence, (18) urinary urgency and frequency, (19) essential hypertension, and countless other manifestations. There is no doubt that gastric and duodenal ulceration when fully developed is a definite organic disease. It is only in its pathogenesis that the neurotic disposition plays a part.

CLINICAL CONSIDERATIONS

The importance of unhealthy emotional reaction patterns is so great that some discussion of them here seems appropriate. These reactions

will be discussed under the following titles: (a) Fear, (b) Inferiority Feelings, (c) Hostility, (d) Emotionally Toned Ideas, (e) Conditioning, (f) Displacement of Affect, (g) Free-Floating Emotion. The most common unhealthy emotional reaction pattern is that of *fear*.

FEAR

Fear, itself, is a healthy reaction of the living organism and is a painful sensation of alarm or disquiet experienced in the presence of unavoidable evil, and justified by the stimulus producing it. Fear is the mobilization of energy to escape or run away from danger. Everyone will experience fear if given the proper stimulus. Absence of fear in the presence of danger is abnormal. *In the normal individual, such an emotion endures only as long as the stimulus is present.*

Fear states have been given a variety of names, all of which refer to the same generic reaction, but are variously used to indicate the intensity, duration, or definiteness of the emotion. Among the synonyms for fear states may be mentioned worry, anxiety, dread, dismay, apprehension, fright, timidity, horror, terror, consternation, panic, shyness, alarm, embarrassment, and despair. *The emotion of fear in any one of the above manifestations becomes pathological when its existence is not warranted by the stimulus producing it.* It is, for example, abnormal to suffer intense fear at the thought of riding in an elevator, to become terrified at the sight of a mouse, to worry about sins never committed. In all such cases, the fears are objectively groundless and the reaction of fear is out of proportion to the stimulus producing it. Such abnormal mental attitudes develop from the employment of unhealthy methods of facing reality. Abnormal fear patterns are the greatest cause of mental disorders.

A special form of fear reaction is that manifested in *inferiority feelings*. Such feelings of inferiority are so frequently found in all forms of neuroses that special attention should be given to them.

INFERIORITY FEELINGS

Inferiority feelings, better known as an inferiority complex, may be defined as a state of mind characterized by feelings of inadequacy, incompetency, or unworthiness due to a pathological fear of oneself in competitive or difficult circumstances. This condition occurs so often that it can be considered an almost universal symptom of the psycho-neuroses. However, its occurrence is so frequently noted in the absence of other symptoms that it deserves special consideration. For this

reason we shall give careful attention to the various parts of the above definition.

Transitory feelings of inferiority are experienced by all. They may, in fact, be considered an aspect of normalcy. Such feelings are frequently justified by circumstances, e.g., when we find ourselves in the presence of people more attractive, more intelligent, and more capable than ourselves. The phenomenon which is of special psychological significance is the habitual state of inferiority and inadequacy experienced by people without sufficient objective justification.

It is a mental condition. Such a deeply rooted sense of inadequacy is not only mental in nature, but is always psychogenic in origin. Any one of a great number of incidents and factors may precipitate or facilitate the development of such conditions, but the agency that causes the state of mind is habitual indulgence in groundless feelings of inability to cope with competitive or difficult situations which arise from obscure elements of which the patient may be unaware. Even organic factors such as freckles on the face, conspicuous nose, or dark complexion may precipitate the complex, but do not cause it. Many people who possess similar traits, who may even have been subjected to ridicule and caustic comment because of them, do not develop the habit of feeling inferior.

Adler developed the idea that neurotic disorders resulted from efforts to compensate for inferiority feelings. He held that inferiority originated in the "consciousness of organic inferiority," i.e., that some organ or organs of the body were undersized, underdeveloped, or in some way below average. Even in Adler's view, neurosis is not due to organic insufficiency, but to the sustained consciousness of such insufficiency. If there is an overconsciousness of a real organic inferiority, however, the result is not actually pathological. If the organic inferiority is more imaginary than real, or if its importance is exaggerated, this is a true sense of inferiority. Any kind of subjectively established inadequacy constitutes the complex.

Instead of "feelings of inadequacy" it would, perhaps, be more accurate to speak of a conviction of inadequacy and inferiority attended by emotional reactions of anxiety and self-consciousness. The condition does not seem to be basically emotional in origin. It is, of course, true that the emotions, particularly fear, play an important part in its formation.

Feelings of inferiority are based on an irrational, pathological fear of oneself. For reasons of which he may be unaware the subject of

such fears is possessed by ideas of inability to cope with certain situations. He feels that he cannot pass examinations, make decisions, meet people, speak in public, hold a job, or get married. Everyone has moderate misgivings on occasions. Most of the time, such feelings are based on objective limitations, but the victim of an inferiority complex has no real foundation for his fear. He is usually capable of passing examinations, generally possesses good intellect, is able to meet social situations, has ability to address public meetings, but he is subjectively convinced that he cannot, and is afraid that, if he tries, he will fail. This fundamental fear of self may remain out of consciousness so that the patient is often unaware of the basic motivation for his thinking and conduct.

The inferiority complex is obviously founded on the motive of fear. In many ways it resembles a phobia and could justly be classified as a phobia of failure in competitive or difficult circumstances. The patient may be able to play the piano well, and when alone he might attempt to do so; but if someone else were present, he would experience a fear of criticism and would suffer by comparison with others.

CASE 6: *Feelings of Inferiority*

The patient, a white male, aged thirty, complained of a constant state of unhappiness which arose from the certain conviction that he was unable to meet the obligations of his state in life. "I'm really good-for-nothing, and I brought it all on myself." According to his history he graduated with honors from high school and college. He had always been well physically, and objectively possessed an attractive personality and was happily married. His position as assistant manager of a large business paid him a more than adequate income to support his wife and three children. He professed a sincere love for his wife, but constantly expressed fear that he would lose her. When asked for an explanation of this statement, he revealed that in spite of the objective evidence of good health, attractive personality, and success in business, he felt socially inadequate, unable to meet people, unsuccessful at his work. He expressed a feeling that he would undoubtedly soon be replaced by a more competent individual and that he would then lose his income and finally his wife and family.

His past history revealed that such feelings of inadequacy had been present at least since the age of five. He was the first son of loving and attentive parents. When he was five years of age, a second boy was born who soon became the center of attention and affection and

the patient felt rejected and was extremely conscious and resentful of the transfer of his parents' affections. These feelings persisted and he developed a conviction of his own uselessness and unattractiveness. About a year and a half later, his paternal grandmother came to live with the family and, recognizing his feelings, lavished upon him the much-desired affection and attention. She died soon thereafter, and he reverted to his former condition. The younger child continued to be the favorite of his parents. During high school days the patient experienced a failure in an elocution contest. This failure and other minor incidents of slight objective consequence helped to intensify his habitual and ever growing sense of social incompetency. After completing college, he met his present wife, but postponed marriage for several years due to the persistent fear that he would never be able to support her, although his income was above average.

ETIOLOGY OF INFERIORITY FEELINGS

The obscure conflict which gives rise to feelings of inferiority is often difficult to determine even after intensive investigations. As noted above almost anyone from time to time experiences unfounded or exaggerated fears, but relatively few develop permanent feelings of inferiority. The feelings of inferiority, once initiated, are continued as in every habit of overindulgence in, or constant repetition of, an act—in this case harmful self-disparagement.

Occasions facilitating or precipitating habitual feelings of inferiority are numerous. No single event can produce the fully developed habit of feeling inferior. Repetition of such events is the important factor. Harsh, unreasonable, disparaging, or critical attitudes of parents or teachers; unfavorable comparison with other children or members of the family; overemphasis on the importance of success in competition; too difficult assignments; excessive discipline at home or at school are frequent factors in developing fear of oneself in competition, and in susceptible people the development of the habit of feeling inferior.

The Complex

The neurotic disturbance under discussion is frequently referred to as an "inferiority complex." This term, properly understood, expresses a psychiatric entity. The term "complex," as usually employed, signifies a state of mind having the following elements:

1. A system of connected ideas, thoughts, or aspirations
2. centered about a definite object,
3. cemented together by a strong emotional factor

4. which exercises a definite influence over the thinking, feeling, and acting of the patient.

As thus understood, the term is commonly used when we speak of an individual having a persecution complex, a health complex, or a money complex.

The essential part of a complex is the strong emotional core around which cluster a host of ideas or desires. The stronger the emotional element, the more pronounced will be the influence on the personality of the individual. For example, a miser, possessed of a "money complex," thinks and talks of money, studies plans to increase his hoard, may starve himself to save money. All of these activities are united and motivated by the emotion of love for gold.

It should be noted that the use of the term "complex," in this sense, differs radically from the Freudian use and interpretation of that term. A complex, according to Freud, is a dominant idea in the realm of the unconscious, around which is assembled a phalanx of primitive, repressed emotions of an infantile or sexual nature. As pointed out elsewhere, it is obvious that all complexes are not sexual in origin or nature.

Complexes may be good or bad, normal or abnormal, healthy or unhealthy, depending upon their nature or the method or extent to which they influence thought or conduct.

Inferiority complexes become unhealthy and abnormal when they become fixed or habitual, when they are out of proportion to the stimulus that arouses them, and when they lead to pathological symptoms, e.g., depression, indecision, or withdrawal.

Symptoms

In general, habitual feelings of inferiority are productive of much unhappiness, inefficiency, and inability to meet social situations. Those affected find the necessary adjustments to life difficult or impossible. When such adjustments are made, it is at the price of great mental anguish. Feelings of inferiority are cumulative, progressive, and productive of intense feelings of insecurity.

Wallin points out two types of reaction to the inferiority complex. They are the "flight" and "fight" reactions. These are methods of relief or escape from the misery engendered by this state of mind. They are, on the whole, inefficient, futile, and harmful to the personality. Under the heading of "flight," he includes the development of introversion and withdrawal tendencies, exaggerated and painful self-

consciousness, avoidance of difficult and competitive situations, chronic indecision and procrastination, habitual daydreaming or fantasy. The "fight" reaction usually takes the form of overcompensation, airs of superiority, boastfulness, habits of irascibility, jealousy, or vindictiveness. The "flight" reaction is exemplified in the following case.

CASE 7: *Feelings of Inferiority Arising From Unwarranted Sense of Shame*

M. W., twenty-year-old female, had always been happy and well adjusted at home and at school. In her second year of high school, she was shocked by the arrest of her father for complicity in a murder case. Although it became apparent later that he was innocent, he was convicted on the first trial. The patient, who had been rather close to her father, was convinced that all her schoolmates and associates believed her father to be a murderer. She abruptly dropped all of her friends, evaded all companionship, and led a life of seclusion.

As a result of her shame, she formulated the policy that she must never form friendships, never love, nor allow herself to be loved, because to do so was to create an occasion for tragedy. She was greatly relieved when she graduated from high school, but to her consternation, she discovered when she matriculated at a nearby college, that many of her old high school friends were on the campus. She immediately decided that the entire student body and faculty were informed of her father's disgrace. Although the incident had been forgotten by almost everyone, M. W. continued her policy of social isolation due to her feelings of embarrassment and shame. She avoided meeting people, took no part in social life, made no friends, and developed many somatic manifestations. Although many years have passed and she has moved far away from the scene of her original disturbance, her symptoms persist. She has recently fallen in love, and although very desirous of marriage, she has been deterred from doing so by her old fears and the resolution based on them of not loving anyone or of allowing herself to be loved.

Prognosis

In general, feelings of inferiority of long standing are difficult to treat. The longer the feelings have persisted, the more deeply they are rooted in the personality, the less is the chance of therapeutic success. For this reason, it may be stated that the prognosis is proportional to the duration of the symptoms.

The implications between inferiority feelings and the psychogenic

cause of a mental disorder are, we hope, obvious. The tissue may be in all respects healthy and yet a psychic disturbance may be in evidence.

HOSTILITY

Hostility or anger is the mobilization of energy to fight and in its fullest implication means the impulse to destroy or kill. It is important to recognize that anger represents the *impulse* to do damage and not the *intent*. It is obvious that the full intent indicated by the definition is not always present and that the impulse may vary from that of inflicting slight pain to serious injury. A quantitative estimation of the strength of the impulse is, therefore, necessary.

The term *aggression* is often used more or less synonymously with hostility but is not properly so used because although an aggressive act may have in it an element of hostility it may tend to be a constructive act whereas hostility always tends to be destructive. In fact aggression has been defined as a primary human characteristic necessary for survival in the struggle for existence. This trait is so important and universal that many have considered that it is inborn — an instinct as important and as essential as the instinct of self-preservation to which it is closely related. Recent investigators are more inclined to view it as an acquired characteristic in spite of its universality.

The most common source of hostility in the individual is *frustration*. Two other common causes are (a) harm done to the individual and (b) any threat to his survival. Frustration, as a source of hostility, is common in children since childhood consists of a series of frustrations of greater or lesser degree. Hostility may be a response not only to actual but to anticipated frustration.

Many psychiatric disorders result from the inability of the individual to handle his hostile impulses. Many a person develops a fear of his hostile feelings and represses them. This may occur without his recognition of the emotion as that of anger. He may call it by another name. Even though he refers to it as "being upset" it is still anger and its repression may result in unpleasant symptoms. This individual is frequently helped if it is explained to him that hostility is a normal response to the stimulus of being frustrated. That this is a natural reaction and has no moral implication. Having received the stimulus he responds with anger but it is not necessary that he should *act* angry or do anything as a result of his anger. This would require an act of his will. It is *acting* angry or nurturing feelings of hostility that gives rise to moral questions.

Anger may accumulate within the individual as is attested by the old saying, "The straw which broke the camel's back." Sudden outbursts of anger on slight provocation result from this cause. Anger may be directed against the individual by himself. This is the usual mechanism in depressions. Many suicides result when an individual, by identifying himself with some other person, frequently one of his parents, may, by hurting himself, be expressing anger toward the other person, "you'll be sorry when I am gone."

Although the repression of hostility is undesirable, it is obvious that it cannot be too vigorously expressed. Even children who are more forthright in the expression of their feelings recognize the necessity of disguising their hostility because of the inevitable punishment which would follow its expression. Each age group, however, has its favorite method of expressing displeasure with the way things are going. The small child screams, cries, hits, bites, or has a temper tantrum. The older child may refuse to eat, may get poor marks in school, destroy property, be insubordinate or insolent. The adolescent may steal, tease, swear, or be sarcastic. Although each expression is different they all mean basically the same thing, viz., anger against someone or some thing. All hostile behavior need not be antisocial behavior—it may be sublimated and express itself clinically as self-assertion, or as competition in games, sports, or business.

Hostility, unless expressed or sublimated, frequently accumulates within the individual and may result in neurotic symptoms or behavior disorders.

EMOTIONALLY TONED IDEAS OR COMPLEXES

Under emotional sway, groups of images may be welded together and establish what is known as a complex (see above). *Complexes, therefore, are combinations of emotionally toned ideas and judgments.* Thinking and conduct are often regulated by complexes. There is obviously an overabundance of feeling in such psychic states and a corresponding decrease in the use of intelligence. The direction of one's thoughts by complexes is known as katathymic thinking. In such cases, groups of emotions influence the imagination and beget new combinations of images, generate complexes, and affect the rational life of the individual.

Man's psychic life may be unduly influenced by emotional thinking. Life seems different to a man under the influence of strong emotions and complexes from that which it was when he followed mere ab-

stract, cold intelligence. While under emotional sway he often feels that certain things are good for him. This feeling may, however, disappear in the fading away of the emotion. The bodily and psychic reactions of men while under the influence of the emotions indicate how completely the whole man entered into the situation. *An emotional response is the joint product of mind, will, and body.* When, however, man is swayed by complexes, he is not his true self. He then lacks the physical and psychic stability or equilibrium necessary for rational judgment. Though intelligence is required for the initiation of an emotion, man, while under pathological emotional sway, may operate practically on a sensory plane, and be guided by his feelings of pleasure or pain. His will and mind are then almost dissociated from the affective life which temporarily directs his conduct. This has deep implications from the point of view of ethical responsibility. In this connection, we refer the reader to any standard manual of ethics which treats of human acts, emotions, and responsibility.

CONDITIONING: SUBSTITUTE RESPONSE

Contrary to appearances, much human conduct and general behavior is not directly in response to present actual immediate stimulation, but to an absent one for which the present stimulation has become a substitute. Many people react to a substitute stimulus as they formerly did to the original situation.

In *conditioning*, a substitute stimulus evokes the same response as previously did the original one. The classic example of conditioning is that of Pavlov's dog. A slight operation was performed on the dog to alter the direction of the flow of fluid from the salivary gland. As a result of this operation the salivary secretion was discharged into a small glass tube rather than directly into the dog's mouth. The flow of saliva into the glass tube or the lack of it was thus observable and capable of being studied. Pavlov presented a piece of meat to a hungry dog. The effect of this was to beget a flow of saliva on the part of the dog. Later on when Pavlov presented meat to the dog he accompanied it with the ringing of a bell. After a certain number of simultaneous presentations of meat and the ringing bell it was observed that the dog would have a flow of saliva on the mere ringing of the bell and therefore in the absence of the meat. The ringing bell had become a substitute for the meat stimulus. The ringing bell now evokes a flow of saliva as formerly did the meat. The dog now responds to

the ringing bell as he previously did to the meat. The entire picture is known as the process of conditioning. A whistle may become a substitute for the ringing bell and evoke a flow of saliva. A note on the piano may take the place of the whistle. A beam of light may become a substitute for the piano note. This process of substitution may be continued almost indefinitely. Hence, at times, it is almost impossible to say what directly motivates conduct.

Dalbiez states very clearly the processes underlying the conditioned reflex.

Its nature is well known. The normal salivary flow produced in a dog by the mastication of meat may be started by any stimulus such as a whistle, a bell, the lighting of a lamp, and so on, when over a certain period the stimulus in question has been constantly used each time the animal has been given its food.¹⁶

Conditioning is built on associations. Association centers around the three well-known laws of similarity, contrast, and propinquity. Death, fear, victory, defeat, success, failure—all such notions do not stand alone. They abound in and bristle with associations. These associations are the causes of substitute responses. There is continuity in the process of association, one notion may arouse a number of others. Each new experience has influence on the trend of future associations.

DISPLACEMENT OF AFFECT

Displacement is known as transfer of affect. In displacement one idea or situation may surrender to another the whole volume of its emotional impact and content. "Displacement may be defined as a shift of emotion, wish, idea, or phantasy from a person or object toward which it was originally directed to another person or object."¹⁷ This means that in displacement the psychic, emotional emphasis or stress is transferred from one object to another, from an essential to an accessory phase of the situation. In displacement so complete is the transfer of emotional impact from one object or situation to another that partial or total oblivion of the original situation follows. "The experience that was dynamic in the production of the neuroses becomes repressed and encrusted with later happenings and is only faintly visible if at all."¹⁸

Displacement differs from the conditioned reflex. This difference is clearly developed by Dalbiez.

We maintain none the less that there is a difference between the conditioned reflex and displacement, at least when displacement reaches

its maximum strength. In the conditioned reflex the affective charge is not really detached from its proper object, the proof of this being that the reaction is not indefinitely maintained. If the conditioned stimulus is used too often without the animal's being presented at the same time with the appropriate stimulus, the dog eventually ceases to react. Be it noted that the animal always reacts to the appropriate stimulus. It is otherwise in absolutely typical cases of displacement. The secondary object keeps its power of releasing the affect indefinitely; the primary object, however, loses this power. In obsessional neurosis the affect leaves the normal representation and becomes attached to an accessory image. So we see that displacement is, in its strict meaning, clearly distinct from the associative reflex, and appears to possess a more or less abnormal character. We must add that according to Freud, displacement is always the effect of the censor.¹⁹

An example may clarify the nature of displacement whose purpose primarily is "to keep the real idea out of consciousness."²⁰

CASE 8: *An Example of Displacement*

A woman experienced profound fear in a room if the door and windows were closed. Similarly, she became anxious when she closed the door of her automobile. Dozens of similar situations caused her extreme fear. So influenced was she by her fear of closed doors that she requested that the doors and windows in all rooms where she worked or resided be kept open. She adjusted the door of her automobile so that it was always open an inch or so. She would walk to the sixth floor of a building rather than ride an elevator.

Investigation revealed that as a young child she and her brothers and sisters, when too noisy, were ordered to the cellar by their irate mother, who then closed its door and left them in darkness as punishment for their misbehavior. The patient related how, as a child, she dreaded the approach of the moment when her mother would close the door of the cellar and leave her in total darkness amid the screams of her brothers and sisters. Her fears then knew no bounds. What we here witness is a transfer of emotion of affect, from the door of the cellar to all closed doors. She responds to these vicarious situations in the same emotional manner she did in earlier days to the door of the cellar.

To discover the associations productive of the above symptoms in the woman, we should not look for the logical but for the emotional factors which unite some elements and keep others apart. For many reasons, the affective connections are not clear even to the individuals themselves. The reason is that because of the original unpleasant

feeling and emotion the cause and effect relationship of her problem or fear was never too clearly established in her mind. The whole issue was beclouded in fear and worry and never, therefore, came clearly into the domain of consciousness. The total situation was interpreted while she was in a state of generalized fear, worry, and anxiety. Nor is it now clear to the woman that the closed door of the room or of an automobile or of the elevator is in any way connected with the closed door of the cellar in which some of her youthful hours were so unhappily spent. Emotion and feeling are still present and thus the issue remains obscured. Yet a little introspection reveals a close connection between them and the woman may easily be re-educated.

Many adult fears can be explained on the basis of displacement. The fear of crowds that haunts the adult today and renders his public appearances a source of agony to himself and often to his audience may be caused not by his present benign audience but by the transfer of emotion from a group in whose presence as a boy he suffered loss of memory and consequent embarrassment.

FREE-FLOATING EMOTION

When an individual represses the source of an unpleasant event or situation, he may disentangle the feeling aspect of the emotion from its cause and thus beget what is known as a "*free-floating emotion*."

In such an individual, even this free-floating emotion may attach itself to another object which has but little or no relation to the original situation. This process may be illustrated by the following incident:

CASE 9: Example of "Free-Floating Emotion"

A young man announced to his fiancé that he wished to break their engagement. This proved most unacceptable to the young woman, but there was not much that she could do about it. She repressed the image of the young man. The chagrin, bitterness, and embarrassment united and formed a most disturbing complex in her life. She became disturbed, worried, and depressed. She lost weight and slept poorly. There was, however, no clear connection in her mind between the broken engagement and her symptoms.

For some time, her symptoms seemed unrelated to any object. Shortly, however, this free-floating complex became connected in her mind with red roses. Her fiancé had given her red roses on the night of his announcement that their engagement was to terminate.

Thereafter, whenever she saw red roses, she experienced an emo-

tional reaction of physical sickness, nausea, and tension similar to that which she previously had on being told by her fiancé of his intention of not marrying her.

Thus, free-floating emotions may not remain free. They may eventually attach themselves to some object which often seems indifferent. This may become the basis of severe anxiety.

SUMMARY

This chapter has dealt with the second important factor in the production of psychogenic disorders, viz., disturbed emotions. The first part of the chapter deals with psychological considerations and in general follows the usual teachings of the scholastic philosophers. An important consideration here is the definition of an emotion. In this definition it should be noted that intellectual cognition is an integral part of true human emotions. The definition of the eleven basic emotions was considered on page 131.

The second portion of the chapter dealt with the more important unhealthy emotional reaction patterns. The important emotions were considered to be fear, inferiority feelings, and hostility. Most space was devoted to feelings of inferiority because such feelings are basic in many psychiatric disorders. Displacement is a very important mechanism in disturbances which are primarily emotional in origin.

FOOTNOTES

1. Roland Dalbiez, *Psychoanalytical Method and the Doctrine of Freud*, trans. from French by T. F. Lindsay (London, New York: Longmans, Green & Co., 1941), Vol. II, pp. 34-35.
2. *Ibid.*, Vol. II, p. 36.
3. James F. Barrett, *Elements of Psychology for Nurses* (Milwaukee: The Bruce Publishing Co., 1930), p. 181.
4. Dom Thomas Verner Moore, *Dynamic Psychology*, 2 ed. rev. (Philadelphia, Chicago: J. B. Lippincott Co., 1926), p. 111.
5. Joseph Jungmann, *Das Gemuth* (Freiburg, 1885), p. 92, quoted by Moore, *op. cit.*, p. 110.
6. Roland Dalbiez, *op. cit.*, Vol. II, p. 36.
7. Vincent V. Herr, *How We Influence One Another* (Milwaukee: The Bruce Publishing Co., 1945), p. 106.
8. William A. Kelly, *Educational Psychology*, 3 ed. (Milwaukee: The Bruce Publishing Co., 1945), p. 164.
9. Patrick O'Brien, C.M., *Emotions and Morals* (New York: Grune & Stratton, 1950), p. 134.
10. *Ibid.*, p. 201.
11. Thomas Aquinas, *Summa Theologica*, I-II, Quest. 41, Art. 4.
12. Kelly, *op. cit.*

13. Walter B. Cannon, *Bodily Changes in Pain, Hunger, Fear and Rage*, 2 ed. (New York and London: D. Appleton & Co., 1934).
14. Edward Weiss and O. Spurgeon English, *Psychosomatic Medicine*, 2 ed. (Philadelphia: W. B. Saunders Co., 1949).
15. Helen F. Dunbar, *Emotions and Bodily Changes*, 3 ed. (New York: Columbia University Press, 1946).
16. Dalbiez, *op. cit.*, Vol. I, p. 83.
17. Percival M. Symonds, *The Dynamics of Human Adjustment* (New York, London: D. Appleton-Century Co., 1946), p. 252.
18. Edward A. Strecker and Harold D. Palmer, "The Recognition and the Management of the Beginnings of Mental Disease," *Psychiatry for Practitioners*, edited by Henry A. Christian, p. 10.
19. Dalbiez, *op. cit.*, Vol. I, p. 83.
20. T. A. Ross, "Psychoneuroses," *Psychiatry for Practitioners*, edited by Henry A. Christian, p. 591.

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ETIOLOGY OF PSYCHIATRIC DISORDERS: VOLITION

THE WILL

As previously described, man has two types of knowledge:

1. Sense knowledge,
2. Rational knowledge.

Man has also a corresponding twofold urge or tendency, sensory and rational, to accept or to reject objects in the world around him when they are represented to him by knowledge. These tendencies or urges of man are referred to as appetitive powers, or appetites, or will. There are two appetites to correspond to the two types of knowledge. These are called:

1. Sense appetite or sensory will,
2. Rational appetite or rational will.

The *intellect* seeks to possess *the truth* about understandable reality. The will, on the other hand, seeks the good, and tends to possess understood good. In discussing the will, it is important to distinguish between sense will and rational will because only the rational will is free.

Sense appetite or will: An object which is presented as pleasurable by the external senses or by the central sense, sense imagination, sense memory, or instinct attracts the sense appetite or will, and necessarily so, as this aspect of appetition possesses no freedom. If the object be presented as unpleasant, the sense appetite necessarily recoils from it. As its name indicates, this is not a rational appetite.

Rational appetite or will: Corresponding to the rational cognitive power in man, but distinct from it, there is another power which tends to possess the object made known to it as good by rational knowledge, or to reject it if it be presented as evil. This ability or faculty is called the *rational appetitive power* and is *better known as the will*.¹ *The will may be defined as that spiritual or supraorganic rational appetitive power which tends to possess an object intellectually presented to it as good or desirable.* The term "will" is usually reserved for the rational will which inclines, seeks, or tends to possess

or to reject objects presented by the intellect as good or evil. This matter is clearly presented by Maher:

The term *appetite* was used in a very wide sense by medieval writers to denote all forms of internal inclination, comprehending alike the natural tendencies or affinities (*appetitus naturalis*) of plants and inorganic substances, which impel them towards what is suitable to their nature, and the feelings of conscious attraction (*appetitus elicited*) in sentient and rational beings. The formal object of the appetitive faculty in this broad implication is *the good*. Under *the good* is comprised, not merely *the pleasant*, but everything in any fashion convenient to the nature of the being thus attracted. Continued existence, felicity, development, and perfection, together with whatever is apparently conducive to these ends, are all in so far good, and consequently a possible object of appetency; whilst whatever is repugnant to them is a mode of evil, and therefore a ground for aversion of the negative activity of the same faculty.

Of conscious appetite the schoolmen recognized two kinds as essentially distinct—*rational and sensitive*. The former has its source in intellectual, the latter in sensuous, apprehension.²

Henri Renard remarks:

St. Thomas points out that the distinction between sensitive and intellectual appetite is made evident from the distinction of the movers or motors of these two appetites. These movers, however, are those things "which are apprehended." For the "appetible" does not move either of these appetites, except as apprehended. Now "what is apprehended" by the intellect and what is apprehended by sense are generically different. Consequently the intellectual appetite is distinct from the sensitive.³

THE WILL NEEDS THE INTELLECT

Though the will makes the act of acceptance or of rejection, yet, as a prerequisite for its activity, it needs the judgment of the intellect concerning the good or evil residing in the object. The will is not, however, compelled by the judgment of the intellect to accept or reject the object presented; it is not forced to follow the greater pleasure. *The will itself makes the choice*. The operation of the will follows after the operation of the intellect. It is as if the will were blind (or rather in the dark), and before it can function it needs the illumination of the intellect. To carry the example further it is not necessary, and, under certain circumstances, it is unlikely, that the intellect will

light up the whole of the object and so may, by presenting only the desirable aspects of the object to the will, evoke its action. From this, it is apparent that action of the intellect is a necessary condition for will activity. Similarly, the will can turn the attention of the intellect to other matters and thus prevent an ultimate judgment. The will thus prevents the advertence of the intellect to a particular conflict, which is thus forced out of consciousness. It might be stated thus: one must see what one looks at in the daylight, but one need not look. Thus the intellect may see good, but the will can refuse to let the intellect look.

Neither space nor the nature of this text permits a further discussion of the interrelations of the intellect and the will. Briefly, however, it may be stated that the *intellect acts upon the will in the nature of a final cause*, while the *will moves the intellect after the nature of an efficient cause*.

THE FREEDOM OF THE WILL

One of the outstanding differences and sources of conflict between the various schools of psychiatric thought has revolved around the question of the *freedom of the will*. Freud flatly rejected it as do most of his followers. We have discussed this point before (see Chap. VII), and so will limit our discussion at this time to briefly presenting the most easily understood proofs of the freedom of the will.

It should be clearly understood that we do not maintain that all acts of the will are free. On the contrary, *many human acts are not free*. It is only maintained that those acts which follow reflection are free. Habit and bodily appetites may influence the judgment which precedes the act of the will and consequently may strongly influence its action. The will in this latter case, although influenced, is not coerced. In regard to the lack of freedom in reference to certain acts, Mercier has this to say:

. . . all acts performed by man are not free. Only those acts are free which are the fruit of reflection. A very large percentage of acts, then, even in the most serious life are not free because done without thought; a larger percentage are suggested simply by the imagination, controlled by passion or self interest, or are due to routine. In the second place, it is a mistake to imagine that free acts are purely arbitrary, proceeding from a will that acts without a purpose. Truly man may be unreasonable if he like. But in point of fact, in by far the majority of cases, men are not unreasonable, but allow themselves to be actuated by a purpose. Thus, not to speak of the last intention

— the seeking after supreme happiness — the instinct of self-preservation, the instinct of propagation, the natural love of parents for children, of children for parents, the striving for well being, or for personal interest, are all so many motors to the will to which it generally responds without making a deliberate choice.⁴

As we have pointed out, there are many factors which interfere with free acts. In these cases the individual is not deprived of complete freedom of activity, but his choice is limited to a greater or lesser degree. Such *obstacles to a free act* may be classified as follows:

1. *Acute or transitory*

- a) Ignorance
- b) Affective disturbances
- c) Compelling impulses and desires
- d) External influences

2. *Chronic or habitual* — included under this heading would be those chronic disturbances of thinking, willing, and feeling that we have been discussing. Father Davis in discussing habitual obstacles to free acts states: "Neuroses may be considered as habitual obstacles to free acts. These diseases add their own momentum, as it were, to the motion of the sensitive appetite; at other times, they prevent the full and free advertence of the intellect. Accordingly, the will is diverted from the pursuit of the true good, and consequently these sufferers are the less responsible."

The acute obstacles are sufficiently clear to need little discussion. *Ignorance* may be vincible or invincible. Vincible ignorance is correctible and, where possible, should be corrected. In some instances, overcoming such vincible ignorance is an effective therapeutic measure. Invincible ignorance, such as that present in the mentally defective, is permanent. Affective disturbances in the form of pathologic emotions of a severe degree are usually recognized as strongly influencing actions and reach their highest degree in the overpowering influence of fear which may literally paralyze the individual both physically and psychically. Compelling impulses reach their peak in the so-called "irresistible impulse" which many believe relieves the individual of legal as well as moral responsibility.

External influences such as threats, coercion, or organic disease merely deprive an individual of his ability to act exteriorly. Such influences can never force the will interiorly.

The extent to which the various neuroses influence a free act will be better appreciated when these conditions are discussed.

Philosophically considered, these defective applications of the will do not indicate any intrinsic defect in the will itself, but merely its defective use. As stated above, the will tends to possess an object presented to it by the intellect as good. "Nothing is willed that is not first known." Although this is true, it is obvious that the intellect may present to the will what is really undesirable under the aspect of good. To the will it is, however, presented *sub specie boni*. Further, the intellect can focus upon the desirable features of an object, leaving the undesirable features out of consideration. *It is in this way that the first step in the development of a neurosis or psychosis takes place. The intellect confronted by painful reality attempts to avoid suffering by focusing its attention on the more comforting aspects of various escape mechanisms (e.g., mental mechanisms) which it presents to the will as good. The will accepts this misdirection sub specie boni, and in this way occurs the first act that, if frequently repeated, may result in a habit. Thus are developed the faulty methods of thinking, feeling, and willing that eventually result in neurotic disorders.* Each act makes its repetition easier.

The usual arguments advanced to prove the freedom of the rational will are:

1. By the testimony of consciousness that we are able, when the mind has advanced reasons for and against any proposition, to choose or not to choose it,
2. By the awareness of our voluntary attention,
3. By the power of choice which we hourly demonstrate,
4. By the self-control which we endeavor to bring into our lives,
5. From the implications underlying the ideas of duty, responsibility, justice, punishments, and kindred notions residing in the minds of all mature adults. Such ideas would be meaningless in the extreme sense were men not free to choose.

PATHOLOGICAL STATES OF THE WILL

There are two defects of the will usually described: (1) want of constancy; and (2) irresolution.

Want of constancy is what is usually meant when an individual is described as lacking will power. Obviously, the will cannot be strong or weak in a literal sense. This defect indicates a want of constancy in the pursuit of a purpose deliberately chosen.

Irresolution refers to a defect in energy: the motor organs are intact, the intellect clear and the judgment sound, the person has a conscious-

BASIS OF PSYCHIC ACTIVITY

RATIONAL APPETITIVE POWER OR THE WILL

The will is the rational appetitive power. It is the cause of volition, the power of self-determination, the source of freedom of choice in men. The will seeks an object made known to it by the intellect as good, or avoids it if it is presented as evil. The will thus depends upon the preceding judgment of the intellect as upon a motive for its own activity. The will itself however, either accepts or rejects the object and makes the act of choice.

MIND, INTELLECT OR RATIONAL COGNITIVE POWER

The mind is man's rational cognitive power which begets ideas, judges, and reasons. The mind stimulates the will by presenting objects to it either as good and as worthy of being chosen, or as evil and thus to be rejected. The intellect is the basic source of mental health and should be employed in the solution of man's conflicts. The same intellect begets both speculative and practical knowledge. The rational will is the appetitive power corresponding to the intellect.

SENSORY APPETITIVE POWER OR THE SENSE WILL

The sensory appetite tends to possess the objects made known to it by sense knowledge as pleasurable or to avoid the objects if they were presented as painful. Objects therefore presented as pleasant or painful by the central sense, sense memory, imagination, instinct, attract or repel the sensory appetite. The sensory appetite is not free.

INSTINCT: An innate, sensuous cognitive power of animals and men which recognizes, without previous reasoning, those factors necessary for individual and racial preservation and well-being.

IMAGINATION:

1. Preserves images.
2. Recalls images.
3. Does not recognize images as past.
4. Combines or creates images.
5. Projects images.

SENSE MEMORY:

1. Preserves images.
2. Recalls images.
3. Recognizes images as past.
4. Does not combine or create images.
5. Does not project images.

CENTRAL SENSE:

1. Perceives
 2. Unites
 3. Classifies
- in man's consciousness the sensations received through the external senses.

ness that he ought to act, and yet it is impossible for him to decide to act.

Yet sometimes the will is dominated by an excess of energy and finds itself governed by its own strong impulses, which at times seem quite irresistible. This is an impulsive state and in its worst stage reaches what we may call moral insanity.

SUMMARY

This chapter has dealt with the third important factor in the development of psychiatric disorders, i.e., disturbance of volition. Knowledge of the material in this chapter is of special importance because much of the dispute concerning psychiatry has revolved around the part the will plays in the development of mental disorders. The freedom of the will has been especially denied by materialistic psychiatry. It is especially important to distinguish between psychic determinism (q.v.) and free choice. We can readily accept the fact of psychic determinism if we except the matter of the freedom of the will. Freud and many of his followers did not do this. Note that no claim is made that all human acts are free. Many of them are not. Neuroses in general are an obstacle to free acts and individuals so affected are in general less responsible for their acts. As long as an individual remains neurotic, and is not psychotic, he retains some degree of responsibility.

FOOTNOTES

1. The term "conation" should be distinguished from the act of willing. According to Noyes, "this term includes an implication of affect and desire as well as the concept of what was formerly included under will" (Arthur P. Noyes, *Modern Clinical Psychiatry*, 2 ed. [Philadelphia, London: W. B. Saunders Co., 1940], p. 122).
2. Michael Maher, *Psychology: Empirical and Rational*, 9 ed. (London, New York: Longmans, Green & Co., 1921), pp. 208-209.
3. Henri Renard, *The Philosophy of Man*, 2 ed. (Milwaukee: The Bruce Publishing Co., 1946), p. 156.
4. Desire Cardinal Mercier, *Manual of Scholastic Philosophy* (London: K. Paul Trench, Trubner & Co., Ltd., 1916), Vol. I, p. 275.

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ETIOLOGY OF PSYCHIATRIC DISORDERS: HEREDITY

Since the "science" of psychiatry has been developing, there has been a gradually increasing tendency to deprecate the importance of the soul and its faculties in philosophical and psychological thought. In general, it may be said that since the time of Descartes (1596-1650) the soul has enjoyed a position of progressively diminished importance. Descartes relegated the soul to the pineal gland and from there it has passed into almost total oblivion in current psychiatric thinking.

The prevalent philosophy of psychiatry leans heavily on the tenet of materialism. As we have repeatedly pointed out, for the materialistic philosopher man is merely the passive recipient of the influences of heredity and environment. Since man is considered only in his physical being this is a logical conclusion. The materialist would naturally consider that man is mechanically determined to follow definite types of activities. Although materialism retains certain terms such as "will," "mind," "intelligence," and "emotions" its use of the words differs radically from the philosophical definitions given these terms by the Scholastic philosophers.

Materialism identifies thought with tissue activity. Sound thought and intact personality to the materialist mean sound cerebral tissue. Psychoses are thought to be the result of pathological or malfunctioning brain cells. It is not strange, therefore, that for the materialist the basic cause of mental illness would be found in heredity: ". . . the brain is the grindstone of thought. . . ."¹ This idea is quite prevalent in the current literature. "Mental deficiency, epilepsy and mental disease," we are told, "do not arise *de novo* in each generation, but are transmitted from parent to child, because these conditions lie inherent in the family stock or germ-plasm."² Again, the same authors tell us: "The search has always been for releasing or inciting factors which culminate in the disease. One set of investigators, who may be called organicists, look for such factors in the form of definite disease processes in the body."³

In spite of an extensive literature in regard to the hereditary influence in the production of mental disorders, there has been very little proof adduced to date that would tend to substantiate the claim that mental disorders or a predisposition thereto are hereditary. We will discuss in some detail the literature of the specific diseases as they are taken up in subsequent chapters; we will not, therefore, go into these details here. It might be stated, however, that we have been unable to find any convincing evidence for the hereditary transmission of mental illness.

There are several *a priori* considerations which, even in the presence of more convincing evidence than is at present available, would raise doubt of the possibility of a physical transmission through the genes. The first of these considerations is the fact that there is a very general acceptance of the psychogenic origin of many of these disorders. It is our own belief that all of these disorders are acquired and that, therefore, being acquired they are not transmissible by heredity any more than the ability of the parent to play the piano could be so transmitted. The second consideration is that, since a psychosis is a psychic, unextended reality, it cannot be transmitted by physical heredity. A material reality cannot, according to the principle of sufficient reason, produce a psychic reality.

REVIEW OF THEORIES OF HEREDITY

Many varieties of hereditary etiology have been proposed as causes of mental disorders. Although some of these have been discarded, others continually recur in the literature. For this reason, a brief review of these ideas seems appropriate.

They will be discussed under the following titles:

1. Psychobiological Constitution
2. Constitutional Predisposition
3. Unstable Make-up
4. Degeneration
5. Polymorphism
6. Organic Lesions
7. Neuropathic Taint
8. Pangenesis and Gemmule Hypothesis

1. *Psychobiological Constitution*

Psychobiology may be defined as a study of the interplay between body and mind in the development and functioning of the individual's

character. It is based on the supposition that there is a deterministic connection between an individual's physical stature and his mental and emotional constitution, and that this may even determine the type of mental disease that appears in the individual.

There has continued down through the years a simple, naïve, and uncritical conviction that there is a connection between physical build and psychic temperament. The very shape of a man's head was supposed to indicate the type of morals he possessed. Such expressions as "He looks like a murderer, a scoundrel, or a saint" are common even today.

It is clear now that such expressions are not to be taken seriously, although they were previously regarded as having some scientific value. Lombroso (1836-1909) taught that the criminal could be detected by his physical contour, the shape of his head, and his general physiological traits. His opinion, however, is now no longer held by reputable scholars.

Kretschmer, a materialist, stressing heredity as a causal factor in the psychoses, called attention to the connection between a particular bodily build and temperamental tendencies, psychic urges, emotional trends, and personality formation. The body build was the gift of organic heredity to the individual. From the body build certain disorders were supposed to originate with deterministic necessity.

For our discussion, Kretschmer's division of men into the pyknic and asthenic types is pertinent. *The pyknic type of individual was one of average height, plump figure, short neck, large chest, and body of solid proportions, with large, benign, kindly features. He was prosperous looking, good humored, and seemed to enjoy life to the fullest, to be replete with energy and vivacity.*

This pyknic type has been described by the *Technical Manual* as characterized by the "pronounced development of the head, breast, and stomach, and a tendency to a distribution of fat about the trunk with a more graceful construction of the shoulders and extremities. An individual of middle height, rounded figure, soft, broad face on a short thick neck and a fat paunch protruding from a deep-vaulted chest which broadens out toward the lower part of the body."⁴

The asthenic or leptic type was of the opposite mold, tall, lanky, weak looking, emaciated; in short, a man of just one dimension — length.

From the standpoint of temperament, *the pyknic type was described as cyclothymic. That meant that those so affected were likely to go to*

emotional extremes, to fluctuate considerably above and below the line of emotional normality.

This individual was inclined to be an extrovert or to direct his energies outward toward objects and people in his environment. He was, therefore, considered to be a good mixer and to be possessed of ample social poise. *The character, point of view, philosophy of life, and temperament of the pyknic individual were joyous and brimming over with a quality of good humor which was contagious and drew people to him.* This type was supposed to be friendly, well liked, able to meet difficulties, to see the silver lining in every dark cloud, and to be almost unduly optimistic. He possessed the necessary qualities to be a good lecturer, salesman, dramatist, or teacher.

The asthenic type, on the other hand, had traits attributed to him which were diametrically opposite to those possessed by the pyknic. Though sufficiently gifted, he was considered to be a poor conversationalist, to lack leadership, to suffer from an inferiority complex, to be pessimistic, moody, and distrustful of himself.

In the literature dealing with the pyknic and the asthenic types of body build, it was pointed out that mental disease does not necessarily follow from the mere possession of one or other of these physical types. It is claimed, however, by most psychobiologists that, in the event of a subsequent mental disorder, the pyknic type develops manic-depressive psychoses while the asthenic or leptic type becomes schizophrenic.

Review of literature on pyknic and leptic types. Today, many students of the subject deny that the pyknic physique is always associated with the cyclothymic temperament and extroversion. In a similar manner, they also deny that the asthenic physique is unfailingly connected with the schizoid temperament and introversion. That body build does not determine personality traits nor ultimately determine which type of mental disorder the patient will develop is the judgment of many who work in mental institutions and whose background has equipped them to offer worth-while judgment in the matter.

Studies show that manic-depressive patients in their prepsychotic state are often gloomy, with a tendency to consider insignificant events as of great importance. Henderson and Gillespie describe manic-depressive psychotics as "quite healthy, though to a certain extent, moody and unstable."⁵ Thus, it does not seem that all potential manics conform to the typical pyknic pattern or cyclothymic temperament.

Pollock, Malzberg, and Fuller,⁶ in a study on the temperaments of

fifty-nine male patients of the manic-depressive type of body build, observed that ten of the fifty-nine associated with boys only, while twelve were poor mixers. From this study, it is seen that twenty-two of the fifty-nine patients do not conform or harmonize with the definition usually given concerning the social traits and possessions of the manic-depressive personality type.

The following diagram, taken from Henderson and Gillespie, illustrates the relative percentage of patients and their temperaments:

Types of Prepsychotic Temperament⁷

	<i>Depressive</i>	<i>Manic</i>	<i>Combined Forms</i>
Depressive temperament	64.2	8.3	27.5
Manic temperament	35.6	23.3	41.1
Irritable temperament	45.5	24.4	30.1
Cyclothymic temperament	35.3	11.7	53.0

Dorcus and Shaffer, describing patients who developed manic-depressive psychoses, observed: "*Many, however, are described as having been gloomy always, never having seen anything but the distressing side of affairs, and having had a tendency to consider insignificant events as being most serious.*"⁸ This observation does not agree with Kretschmer's or Jung's description of the pyknic type.

Parental training shapes character. It is well known that parental influence and early training may, to a remarkable degree, make children either buoyant or depressed, introverts or extroverts. Parents may train their children to be alert, aggressive, open, talkative, or they may force them to be retiring, shy, and lacking in confidence. Traits thus developed may be the foundation for subsequent habits in the life of the individual.

Much, therefore, of what is treated as cyclothymic temperament and its "clear biological affinity with pyknic body-build" can be explained as the influence of early training.

It is a matter of interest that so much space is dedicated in contemporary psychiatry to the psychobiological constitution. Forty-one textbooks on psychiatry, chosen at random, reveal that that number of authors accept the psychobiological constitution as affording an explanation of the etiology of the psychoses. The interplay of pyknic body build, cyclothymic temperament, and extroversion, or the interplay of asthenic body build, schizoid temperament, and introversion are supposed to explain adequately the whole causality. Pollock tells us that "it is easy to show many exceptions to this alleged association; but

more important is the fact that it is impossible to demonstrate that the physical constitution is the cause of mental make-up."⁹ We agree.

2. *Constitutional Predisposition*

Many psychiatrists explain transmission of mental disorders through what they call "constitutional predisposition." They look upon this "constitutional predisposition" as the result of heredity. It is not, however, strictly correct to attribute all constitutional predisposition to heredity. The "constitutionally predisposed" patient, when he becomes a psychotic, is the result of both heredity and environment. This environment may mean his early training, his power of adaptation, his successes and failures, and his reactions to these incidents. This constitutional predisposition and the subsequent mental disorder are supposed by many psychiatrists to be due to cellular changes. However, it is granted by all that hereditary influence is complete at the moment of conception. From that moment onward, it is a question of environment. Constitutional predisposition, therefore, means not only the influence of heredity but also the patient's reaction to his environment.

3. *Unstable Make-up*

The same is true of what is called the "unstable make-up." This is treated as though it were directly derived from heredity. Now "unstable make-up" like "constitutional predisposition" implies not only the influence of heredity on the person, but also the impact of environment on him, his personal response to life and to the happenings of his career. Character is not inherited, but acquired. As Dubois has well said: "To speak of heredity is to indicate transmission by somatic channels. We do not inherit feelings, still less ideas; the world of mental representations only arises later."¹⁰

4. *Degeneration*

Heredity implies resemblance based on organic descent. It is certain that physical similarities are transmitted by way of heredity. Many psychiatrists have claimed that not only the physical traits, but also the mental and psychic likenesses are also transmitted by heredity. They have maintained that the mental and moral traits of children of the same family bear a strong resemblance to similar traits in the parents and have a high correlation with the same traits as found in other children of the same family. The children's honesty, thriftiness, social competence, and aggressiveness are supposed to be correlated as are the physical traits, e.g., their facial appearance, or their height and weight.¹¹

The fact overlooked in this conclusion is that while such traits as honesty, industry, and politeness are begotten by education, by parental influence, by imitation, and by similarity of environment they could not be produced by physical generation or heredity. Honesty, industry, zeal, politeness, standards, and moral principles are not material realities and, being totally devoid of size and extension, are incapable of being transmitted by protoplasm or heredity.

Investigators began to discuss the transmission not only of perfectly normal mental traits but of psychotic disorders from parents to child. This hereditary transmission of mental disease was variously explained and under different names. All of them, however, start from the same premise, that mental disorder is the result of heredity. The disorder, these investigators claimed, was imbedded in the protoplasm and thus transmitted to the offspring. The reader is referred to the writings of Morel.¹²

A very popular method of explaining the supposed hereditary transmission of mental disorder is known as *degeneration*. Degeneration means a change in structure by which an organism becomes less elaborately developed and thus reverts to a lower type. It is a sort of evolution in reverse, a devolution. This doctrine maintains that physical disorders appearing in the ascendants or ancestors reappear in the descendants in a more malignant form, until the line finally dies out in the fourth generation.

As applied to mental disorders, degeneration meant that a psychic disturbance, presumably initiated by direct disintegrating influence of psychic or environmental factors on the germ plasm of the great-grandparents, would result in a psychosis in the fourth generation. The sequence of steps in the development of a mental disorder as explained by the proponents of degeneration is roughly as follows:

a) The first generation, great-grandparents, would display a mildly nervous temperament.

b) The second generation, grandparents, would manifest traces of neurosis.

c) An innate tendency to psychosis would characterize the third generation, or parents.

d) A fully developed psychosis would develop or appear in the fourth generation.

The degeneration theory is most misleading. At best, it can explain how physical realities descend to a lower, inferior level of existence. Even this we doubt. Moreover, degeneration looks upon thought solely

as the result of brain activity. It does not grasp the real nature of mind, thinking, or of reasoning. Any beneficial influence that may be exerted by education is ignored. Its doctrine that insanity becomes innate in the third generation is especially reprehensible.

5. *Polymorphism*

One of the greatest stumbling blocks for the theory of psychic heredity is its lack of scientific confirmation. It is admitted that insane parents may beget sane offspring, while perfectly normal parents may have children who are feeble-minded or who may eventually become neurotic or psychotic. This means that at times there is very little if any resemblance between the mental or psychic traits of parents and those of the offspring.

This fact, also, is noted by many students. Henderson and Gillespie, for example, say: "When this type of disorder, manic-depressive psychosis, exists in the parents, the same type is likely to show itself directly among the descendants; but other types of mental disorder may also occur, e.g., schizophrenia."¹³

Strecker, observing that the mental traits of parents are not necessarily transmitted to the offspring, remarks: "Direct inheritance may be very significant, but even when it exists, its effect is more likely to produce heterogenous constitutional liabilities rather than the same psychosis."¹⁴

Tredgold agrees with Henderson and Gillespie and Strecker. He observes:

. . . in Huntington's chorea, and in a proportion of cases of manic-depressive psychoses, mental instability, and epilepsy, a similar condition has existed in the ancestors. In most cases, however, this is not so, and the patients come of stocks characterized by members suffering from different kinds of mental abnormality. Thus, one member may be a manic-depressive, another a schizophrenic, another a sufferer from pre-senile dementia, mental defect, mental instability, or a psychoneurosis. In other words, in the majority of cases of mental disorder the inheritance appears to take the form of a general, rather than a specific, predisposition to mental disease. It is then appropriately termed a psychopathic diathesis.¹⁵

The proponents of organic transmission of mental disorders saw this difficulty and tried to explain it by the introduction of a new word, "polymorphism." *Polymorphism* means, literally, many shapes or many forms. As it concerns us here, the term means that one type of disorder, be it a neurosis or psychosis, existing in the ascendants may

manifest itself under various forms or shapes in the descendants.

This explanation may obviously be used against the proponents themselves, whether they adhere to Mendel's laws or not. When there is a question of heredity, there is the assumption that a resemblance is being transmitted. And yet in the case of polymorphism this similarity is lacking. Polymorphism is at best an admission of the weakness of the hereditary theory of psychic transmission.

6. *Organic Lesions*

Those psychiatrists who view man as a purely physical being can conceive of mental disease only as rooted in the brain or other body tissues or as a reaction of protoplasm. They look upon thought as a reaction of cerebral tissue. In this concept, of course, emphasis is placed upon association tracts, neural arcs, and the synapse. For them brain tissue may be compared to the hat which a man might wear. If the hat is devoid of holes, the shadow cast is likewise devoid of holes and is looked upon as being perfect. If there be holes in the hat, the shadow is a pathological one because it is imperfect, or has holes in it.

In a similar way, the organicist reasons that if the tissue of the brain is sound, the thought is sound and the man is mentally sound. On the other hand, if the brain tissue is diseased or has a lesion, the thought is considered diseased and there is a mental disorder.

The explanation of mental disorder by organic lesion is similar to that of degeneration. Thought is, it is claimed, as extended as is matter and depends on the varying conditions of matter. If matter becomes pathological or suffers a lesion so also does thought suffer a similar fate. A grave lesion to tissue may mean a grave disorder in thinking.

Tredgold says: "The disorder of thinking may be explained by the *dissociation of the mechanism* whereby thoughts are held together in logical sequence and relationship and those who held the view that this has a material basis will doubtless regard it as due to degenerative changes in the higher cerebral *association centers*. The general effect of this disorder is to produce a jumbling, rambling, and incoherence of thought, and this in turn causes several *psychic phenomena*. Thoughts take fantastic and kaleidoscopic turns so that some patients say they have no control over their thinking, or that ideas are put into their minds by outside influences."¹⁶

Although we recognize the widespread belief in some schools that eventually an organic basis will be found which will explain the

pathology of mental diseases, no such basis has as yet been found. It is our belief that no such cause exists. In support of our opposition to a possible organic etiology we would like to point out, in addition to what has already been said, the following:

a) Organic lesion is built on a false philosophical premise, that matter can beget thought, normal or abnormal. This is, however, intrinsically impossible. Nothing that is purely material can beget a psychic effect. No effect can be superior to its cause.

b) An organic lesion may render all thinking impossible. It is established in elementary psychology that the soul, through the activity of the mind, begets ideas, judges, and reasons. To do so, however, the soul and mind depend upon integrated brain tissue as upon a necessary condition for their own spiritual functions. If the brain tissue have the lesion referred to, it may lack the integrity or perfection necessary for its co-operation with the soul and mind. The deeper the lesion the less chance there is for the appearance of any thought.

It is well to remember that the organic lesion when proposed as the cause of a mental disorder is based on the supposition that thought results from tissue activity, from the interaction or friction of brain cells; that knowledge is as spatially extended as is the brain tissue; that thoughts and judgments as well as reasoning are derived from purely material antecedents.

c) Even the presence of an organic lesion would not "dissociate" an idea or judgment. Dissociation is a metaphor when applied to psychic life or to ideas, and something entirely real when applied to the brain tissue. Ideas cannot be divided into parts. It is impossible to dissociate an inferiority complex or the notion of justice, right, or duty. Brain tissue, on the other hand, may be easily dissociated. The brain is not, however, identified with thought. The fate of tissue does not become that of thought.

d) If the disorder were caused by dissociation or lesion of the brain tissue, how, with the continuance of the same dissociation or lesion, can the patient recover? It is well known that degenerated brain tissue does not regenerate. Brain cells are not rebuilt and yet the patients frequently recover.

e) Many patients with extensive brain damage do not develop mental disorders. No one, for example, by an examination of the brain of a senile patient could describe the amount of mental damage which the patient had before death. There is no quantitative relationship between brain damage and mental abnormality.

f) Many outstanding scientists have denied the existence of any organic lesion in mental disorders. For citations from those authors reference should be made to our discussion of the manic-depressive and schizophrenic psychoses.

7. *Neuropathic Taint*

The theory of neuropathic taint maintained that mental disorders had their origin in diseased tissue or germ plasm. It taught that the diseased organic conditions of the ascendants would assert themselves in the descendants in one form or the other (polymorphism, or psychic equivalent).

This neuropathic taint, or unity of organic disease in the ascendants, was not, however, directly and immediately visible and tangible in itself. The problem, therefore, of how to detect the presence of this organic disorder in the ascendants became important. It was finally decided that the neuropathic taint in the ascendants asserted itself by the presence of the so-called "tainting factors."

The organic unity of the disorder was arrived at through these tainting factors. Neuropathic taint meant that, if malignant tainting traits were found in the ancestors, they would reappear in the offspring.

Heredity was considered as direct (father and mother), indirect (grandparents, uncles, aunts), and collateral (brothers and sisters).

In looking for neuropathic taint which was supposed to manifest itself through the media of "tainting factors," investigators included many vague, indefinite, intangible, and unrelated factors. Various authors differed on the elements to be included in "tainting factor." One author considered them established if any one of the following traits were found in the family history: (1) mental disease, including epilepsy, hysteria, and hypochondriasis; (2) nervous disease; (3) alcoholism; (4) apoplexy; (5) dementia senilis; (6) eccentricity; (7) suicide.

Another investigator included in his study the following tainting factors, any one of which was supposed to manifest the neuropathic taint: (1) psychoses; (2) idiocy; (3) epilepsy; (4) suicide; (5) eccentric character; (6) nervous diseases; (7) alcoholism; and (8) apoplexy.

A third investigator enumerated the following as tainting factors: (1) mental diseases, including general paresis, and congenital and acquired feeble-mindedness; (2) functional nervous diseases; (3) organic nervous disease (including tabes and epilepsy); (4) apoplexy; (5) alcoholism; (6) dementia senilis; (7) suicide; and (8) character anomalies.

An investigation made by Koller,¹⁷ in 1895, throws some light on the lack of value possessed by "tainting factors and neuropathic taint." She examined the ancestors of 370 mentally healthy people and the ancestors of 370 who were mentally sick. She considered neuropathic taint, tainted heredity, to be present *if any of the following factors were found* in the family history: (1) mental disease including epilepsy; (2) hysteria; (3) hypochondriasis; (4) nervous diseases; (5) alcoholism; (6) apoplexy; (7) dementia senilis; (8) eccentricity; or (9) suicide.

Koller found (1) that the family history of the healthy group displayed more hereditary taints in nervous disease, apoplexy, dementia senilis, and suicides; (2) alcoholism, nervous disease, and apoplexy represented in the healthy group 55, 38, and 36 taints, as compared with 63, 29, and 16 taints, respectively, among relatives of the diseased group; (3) the investigation further revealed that the grandparents, uncles, and aunts of the healthy group had 96 taints, while those of the diseased group had but 45—a ratio of 1 to 0.5.

Not only are many of the tainting factors vague and indefinite but their existence may be frequently attributed to the subjective and preconceived notions of investigators.

At one time the theory of neuropathic taint was widely received. New York State Hospital, for example, assumed that "tainted heredity" or "neuropathic taint" was present if any of the following factors could be observed: "mental disease, psychopathic personality, nervous disease, mental deficiency, and alcoholism." This hospital turned in figures stating that 43.5 of its patients had neuropathic taint in 1920; 43.6 in 1921; and 54.4 in 1923.

Psychiatrists and investigators claimed "neuropathic taint" in a very high percentage of their patients. Morel stated that he found tainted heredity in about 20 per cent of his patients; Esquirol in 56 per cent; Kraepelin in about 20 per cent; Bleuler, 80 per cent; Saiz mentions 84.7 per cent; Waygane states 90 per cent; and Albrecht gives 80 per cent.

Suffice it to say that, although occasional references to neuropathic taint may still be found, the theory has no longer any wide acceptance.

8. *Pangenesis and the Gemmule Hypothesis*

Pangenesis was originally formulated to account for the *hereditary transmission* of likeness. Pangenesis is defined as "a name given by Darwin to his hypothesis which he advanced to explain the phenomena

of heredity, that every separate unit or cell of an organism reproduced itself by contributing its share to the germ or bud of the future offspring."¹⁸

Pangenesis maintained that not only did the cell multiply itself by self-division or proliferation but, further, that each cell or unit throws off undeveloped atoms or granules or gemmules. Gemmules are defined as the hypothetical units conceived as capable of reproducing the part from which it is thrown off. These gemmules were supposed to account for the transmission of physical similarities. We quote from Darwin: "This important distinction between transmission and development will be easiest kept in mind by the aid of the hypothesis of pangenesis. . . . According to the hypothesis every cell or unit of the body throws off gemmules or undeveloped atoms which are transmitted to the offspring of both sexes and are multiplied by self-division."¹⁹ Darwin again tells us: "I . . . assume that each unit casts off free gemmules which are dispersed throughout the entire system and are capable under proper conditions of being developed into similar units."²⁰

In his theory of pangenesis, Darwin proceeds to state that different parts of the body become changed because of changed environmental conditions. Parts thus affected or modified throw off gemmules which are correspondingly changed and modified. These altered gemmules are transmitted to descendants and in them the change becomes perceptible. Darwin states: "In variations caused by the direct action of changed conditions of which certain parts of the body are directly affected by the new conditions and consequently throw off modified gemmules, which are transmitted to the offspring."²¹

For Darwin, the materialist, thought is but a manifestation of brain tissue and mental diseases merely manifest altered or pathological tissue. He tries to account for mental disease in terms of modified gemmules. He tells us: "With respect to mental habits or instincts we are so profoundly ignorant of the relation between the brain and the power of thought that we do not know positively whether a fixed habit induces any change in the nervous system although this seems highly improbable; *but when such habit or other mental attribute, or insanity, is inherited we must believe that some actual modification is transmitted and this implies according to our hypothesis that gemmules derived from modified nerve cells are transmitted to the offspring.*"²²

Darwin, therefore, takes for granted that physical and psychic

modifications appearing in posterity result from heredity. Psychoses according to Darwin result from the transmission of modified nerve cells to the offspring.

By way of brief summary, the steps of Darwin's doctrine of pangenesis and the gemmule hypothesis may be put into the following sequence:

1. Cells multiply themselves by self-division.
2. They also throw off undeveloped units known as gemmules.
3. These gemmules have likewise the power to multiply themselves.
4. They ultimately become lodged in the sex cells and are thus transmitted to posterity.
5. The gemmules reproduce the parts from which they were thrown off, hence similarity between ancestors and offspring.
6. Different parts of the organism are modified by direct influence of environmental conditions on them.
7. The parts thus changed throw off modified gemmules.
8. In this way, children inherit the changed body conditions of their ancestors. Thus are explained the physical differences in the offspring.
9. Thought and tissue are identified. Mental disorders are caused by pathological tissue.
10. Mental disorders are organically inherited.
11. Darwin explains the organic inheritance of a psychosis by saying that "gemmules derived from modified cells are transmitted to the offspring."

Discussion of Pangenesis. This opinion of Darwin, so enthusiastically embraced when it was first described, is no longer held by most students of the subject. It has been demonstrated that each part of the body, or each particular organ, does not contribute its mite or its gemmule to the sperm or egg. Nor do eggs and sperms gradually change as do the bodies of the parents, nor is the child determined to be what the parents were at the time of the child's conception. It is accepted by all scientists today that there is no change in the sperm or egg corresponding to the change in the parents, nor are the chromosomes which the cells contain made up of gemmules or contributions from various parts of the body.

The human life begins with a single cell, which contains 48 chromosomes. This cell divides and redivides and in this manner gives rise to numerous cells. Some of these cells in turn give rise to muscles, some to skin, bone, and different other parts of the

body. A certain number of cells, however, are "destined for posterity and do not enter into the regular constitution of the body."²³ Nothing that happens to the bodies of the parents through their lifetime can be communicated to the germ cells. On this matter, Scheinfeld observes: "The chromosomes in our germ cells are not affected by any change that takes place within our body cells."²⁴ "Reluctantly," Scheinfeld continues, "we must abandon the belief that what we in one generation do to improve ourselves, physically and mentally, can be passed on through our germ plasma to the next generation. It may not be comforting to think that all such improvements will go to the grave with us."

For other studies on Darwin's pangenesis and gemmule theory, we recommend the reader to the writings of Dobzhansky²⁵ and Lvsenko.²⁶

CANDIDATES FOR PRIESTHOOD AND RELIGIOUS LIFE WITH PSYCHOTIC PARENTS

Contrary, therefore, to the popular belief, it is established that psychoses cannot be transmitted by way of organic heredity. There is no reason, therefore, why anyone who is normal at birth should later on necessarily develop a psychosis. For that reason, those charged with the responsibility of choosing candidates for the priesthood or the religious life should be mindful of this fact.

It is true that the domestic environment begotten by the presence of a psychotic member may become somewhat depressing and its continued influence may prove quite debilitating psychically. This is what is called "social heredity." It may never, however, do any damage to the individual.

If the candidate has the necessary moral habits, as well as fairly good health, average mental ability, and facility in social adaptation, he gives sufficient hope for success, regardless of the mental disorders that might be in his family background, and he should be encouraged in his zealous aspiration.

SUMMARY

We have briefly reviewed some of the principal theories which have been advanced to explain the heredity transmission of mental disease. Most of these now have only historical value. They have been described, however, because in one form or another they are constantly reappearing in the current literature. More specific discussion of current ideas relating to the hereditary transmission of

psychiatric disorders will be given in the chapter devoted to each of these disorders.

FOOTNOTES

1. Roland Dalbiez, *Psychoanalytical Method and the Doctrine of Freud* (New York: Longmans, Green & Co., 1948), Vol. II, p. 235.
2. Horatio Pollock, Benjamin Malzberg, and Raymond Fuller, *Hereditary and Environmental Factors in the Causation of Manic-Depressive Psychoses and Dementia Praecox* (Utica, N. Y.: State Hospitals Press, 1939), p. 11.
3. *Ibid.*, p. 308.
4. U. S. Army, "Outline of Neuropsychiatry in Aviation Medicine," *Technical Manual 8-325* (Washington, D. C., 1940), p. 29.
5. D. K. Henderson and R. D. Gillespie, *Text-Book of Psychiatry* (London: Oxford University Press, 1944), p. 258.
6. Pollock, Malzberg, and Fuller, *op. cit.*, p. 192.
7. Henderson and Gillespie, *op. cit.*, p. 258.
8. Pollock, Malzberg, and Fuller, *op. cit.*, p. 192.
9. *Ibid.*, p. 309.
10. Paul Dubois, *The Psychological Origin of Mental Disorders*, trans. by Edward G. Richards (New York, London: Funk & Wagnalls Co., 1913), p. 67.
11. K. Pearson, "On the Inheritance of the Mental and Moral Characters in Man, and its comparison with the Inheritance of the Physical Characters," *Biometrika*, III, 131-190, 1904.
12. Dubois, *op. cit.*, p. 67.
13. Henderson and Gillespie, *op. cit.*, p. 221.
14. Edward A. Strecker, *Fundamentals of Psychiatry* (Philadelphia: J. B. Lippincott Co., 1943), p. 12.
15. A. F. Tredgold, *Manual of Psychological Medicine* (Baltimore: The Williams & Wilkins Co., 1943), p. 16.
16. Tredgold, *ibid.*, p. 127.
17. J. Koller, "Beitrag zur Erblichkeitsstatistik der Geisteskranken in Canton Zurich," *Archiv fur Psychiatrie*, XXXII-1, 268-294, 1895.
18. *Oxford Dictionary Supplement* (Oxford: Clarendon Press, 1933), p. 422.
19. Charles Darwin, *Descent of Man*, 1 ed. (New York: Thomas Y. Crowell & Co., 1871), p. 271.
20. Charles Darwin, *The Variation of Animals and Plants under Domestication* (New York: Appleton & Co., 1898), p. 371.
21. Darwin, *Descent of Man*, p. 376.
22. *Ibid.*, p. 376; italics ours.
23. Amram Scheinfeld, *You and Heredity* (New York: Frederick A. Stokes Co., 1939), p. 12.
24. *Ibid.*, p. 17.
25. Theodosius Dobzhansky, "A Review of Lvsenko's Genetics," *Journal of Heredity*, 37:1, January, 1946.
26. Trofim D. Lvsenko, *Heredity and Its Variability*, trans. by T. H. Dobzhansky (New York: King's Crown Press, 1946), p. 65.

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ETIOLOGY OF PSYCHIATRIC DISORDERS: OCCASIONS AND CONDITIONS

SUBSIDIARY FACTORS IN THE ETIOLOGY OF MENTAL DISEASES

Many factors are merely the occasions or conditions of mental disorders. As such, of course, they are important, but should not be confused with the principal cause. Careful analysis and thorough study of the numerous details of the case are the only guarantees of correct information on the exact part played by each contributing factor.

We refer the reader to what was said earlier on the nature of *occasion*, *condition*, and *cause*.

Some of the more important occasions and conditions of psychoses are the following: (*a*) overwork, (*b*) social and economic tragedies, (*c*) serious illness, (*d*) war, (*e*) sexual instinct, (*f*) alcohol.

OVERWORK

Overwork was formerly considered an important cause of mental disorders. It is true that some mental patients exhibit extreme devotion to the performance of manual or mental labor, but this overactivity is not a cause of mental disease. More often it is an effect of a disordered mind; sometimes it may precipitate a psychosis or a neurosis.

SOCIAL AND ECONOMIC TRAGEDIES

It is quite true that mental disorder has frequently followed great personal tragedy, be it economic or social. Such events have assumed the role of causal significance in the popular mind, for very often they are much more impressive than the more hidden and much more potent forces in the human personality.

Incidents of this nature occur in the lives of nearly everyone and yet it is certainly true that not all thus afflicted contract mental

disease as a result. The basis for the differences in their reactions to similar tragedies is the element which is so frequently overlooked, namely, the individual's inner power of reaction and assimilation, his philosophy of life, his system of values, and his habitual self-control.

When the victim of tragedy is inadequately supplied with these inner dynamisms the outcome of the tragic incident may be unfavorable, for his urge of escape may lead him to some form of escape. If, however, the individual has sufficient power within himself, he will probably be able to meet the tragedy frontally, solve it reasonably, and retain his mental equilibrium in the face of the same pain and suffering that has defeated his less well-equipped fellow sufferer.

CASE 10: *Neurosis Precipitated by Tragedy*

A male patient, 33 years of age, who had spent many years of active duty in the military service, was put on the sick list because he had reported with incomplete orders. Investigation showed that he had been recommended for emergency leave because of his reaction to his wife's death and the emotional stress incidental to this.

On admission to the hospital, he was moderately depressed. History showed that following receipt of the news of the sudden death of his wife due to drowning, he had a severe reaction characterized by anxiety and depression and he was unable to carry on with his work.

Physical, neurological, and routine laboratory examinations were essentially negative. Mental examination showed him to be moderately depressed, lacking in interest and initiative. Petulance and rebellion were present and not far beneath the surface.

During the first four or five weeks in the hospital, the patient drank considerably when on leave and he had one brief period of anxiety when it was necessary for him to make disposal of his wife's belongings. During the next four weeks, he showed gradual improvement and was returned to duty.

In this instance, grief was followed by a severe reaction characterized by anxiety, depression, inability to work, rebellious attitude, and heavy drinking. Such reactions are not customary or expected under similar stimuli and can only be satisfactorily explained by the supposition that previous to the incident the patient gradually developed an undesirable pattern of life conduct, faulty habits and attitudes that on the occasion of the wife's death culminated in the situational neurosis. If this supposition is correct, the previously developed outlook and habits are primarily responsible for the neurotic development and the death of his wife was only an occasion for it.

SERIOUS ILLNESS

Bodily illness is an organic fact. Certain types of bodily disturbance may lead to temporary or even permanent mental derangement. Of these states more will be said in the treatment of organic and toxic mental disorders. Most illnesses of the body have no necessary causal relationship to disordered mental states.

In these instances where there is a temporal relation between sickness and mental disorder, the organic illness or disease is merely an occasion facilitating or precipitating the production of neurotic or even psychotic states; e.g., painful arthritic conditions, especially if they are prolonged, may easily occasion the development of anxiety or other neurotic reactions. For many it is difficult to sustain physical pain or organic illness for any length of time without developing some neurotic trend. A high percentage of hospitalized patients who presumably have organic illness are actually experiencing somatic manifestations of an emotional disturbance.

It is not a matter of cause to effect, but of occasion to effect. The real underlying causes here also are the unhealthy mental and volitional habits and the defective personality controls.

WAR

The terrible features of actual warfare with its proximity to bloodshed, serious injury, and horrible and instant death constitute one of the greatest stresses to which the human personality can be submitted. Even the very prospect of such impending horrors is a serious hazard to mental health. Terrible agency that it is, war is not a necessary cause of psychogenic mental disorder. If it were, all those who took part in armed conflict would return as victims of neurosis or psychosis. Yet many of those who participate in the savage business of organized battle return mentally normal. The prospect or reality of warfare only facilitates or precipitates mental disorder in minds predisposed by the acquisition of habitually imperfect attitudes toward the problems of life. Personalities equipped with the proper outlook, minds that are hygienically trained will survive the horrors of bloodshed and warfare. In this regard, war belongs to the same general category as social and economic tragedies and illness. At most, it is a moral cause in the wide sense of the word. It is, however, probably the most drastic and potent of all occasions that conduce to abnormalcy.

Life in the armed services is in itself an experience that brings many new forces to bear on personality and requires much adjustment. The routine and repetitive nature of military regime may prove excessively boring and even mentally dangerous for ill-equipped personalities.

CASE 11: *Anxiety Neurosis With Poorly Suppressed Hostility*

On admission to a hospital, a 26-year-old man complained, "I cannot take an order unless I get mad." His history showed that he was always considered "nervous and high-strung" as a child; that he was punished more than the average child; that most of his people considered him the "black sheep" of the family; that, when excited, he stuttered and stammered; that he walked and talked in his sleep; that he feared the dark up to the age of 19; that he had frequent bad dreams and nightmares; that he was hot-tempered and inclined to get into fights; that he felt as though nobody cared for him; that he was uncomfortable in crowds; that all of his symptoms became worse when he "was accused of a buddy's death"; that he completed the eighth grade at the age of 17; that he learned with difficulty and was in constant trouble with his teachers; that he ran away from home frequently; and that he was in frequent difficulty with the police.

Physical, neurological, and routine laboratory examinations were essentially negative. Mental examination showed he was tense, tremulous, hostile, sullen, and resentful. His interest and attention were entirely centered on the imagined wrongs suffered while in the military service. Speech was clear, coherent, and relevant, delivered in short, clipped tones. He expressed extreme hostility toward the armed service and toward "certain individuals" in it.

There was no record of previous illness. He had combat duty in New Georgia. According to the patient's own statement, "I had at least fifteen court-martials and I have had three remitted."

The patient was obviously poorly prepared for the rigors of military life. Previous training and development were certainly inadequate for a type of existence that requires a well-balanced personality. The poor development and nature of the patient's character would probably render him unable to succeed in any type of life and it is little wonder that the severity of life in the Armed Forces precipitated the mental disabilities here recorded.

SEXUAL INSTINCT

The sexual instinct has often been considered as an important factor in the genesis of psychogenic mental disorders. Because of the

Freudian influence, there has been much emphasis on sex as a cause of mental illness. Fortunately, the general modern trend is toward a more sensible and objective point of view.

The sexual appetite *per se* looms large as a factor both in normal and abnormal people. If there is a proper attitude toward it, based on a clear understanding of its purpose, and a healthy self-control, it plays an important part in the evolution of a well-balanced normal character. It is only when improper attitudes are developed toward sex, when it is uncontrolled or misused, that it becomes a serious factor in the development of mental disorders.

Misunderstood or abused sex can contribute to abnormalcy. However, it often appears in the clinical picture of mental patients more as a symptom of the underlying condition rather than as a cause. Erroneous ideas concerning sex indulgence, such as "masturbation causes insanity," "kissing may cause pregnancy," "sex life is *per se* sinful or morally degrading," may occasion sustained feelings of fear, anxiety, and guilt that are objectively groundless and may contribute to neurotic and even psychotic development. Excessive preoccupation about the facts of sex life, prolonged daydreaming about sex experiences, real or imagined, are unhealthy mental states. Improper or deficient education in sex matters may contribute to sexual maladjustments and cause unnecessary psychic pain.

But more important than any of these as a potential factor of twisted mentalities is the lack of self-control in sex matters. William Lyon Phelps¹ has said that important as sex instruction might be to a successful marriage, character, i.e., self-control, was more important.

The extent to which self-control is required depends on one's state in life. It differs for premarital, marital, and celibate states. But in all, control is essential. Lack of it brings maladjustments, psychic stresses, and unhappiness which, when chronic or habitual, may seriously interfere with normal development or even contribute to personality distortions.

ALCOHOL

The excessive use of alcohol has long been considered as an important factor in the production of neuroses and psychoses. Recent studies indicate that alcohol is less frequently causative than was taught at one time. For example in Korsakow's Psychosis the peripheral neuritis is due to a vitamin deficiency induced by the anorexia accompanying the alcoholism rather than to the alcohol itself. Alco-

holism is more frequently symptomatic of a neurotic disturbance than causative.

In his book, *New Facts on Mental Disorders*, Dr. Neil Dayton² indicates that alcoholism was found to be a causal factor in one fifth of 89,190 admissions to the mental hospitals of Massachusetts during the years 1917 to 1933, inclusive. He berates psychiatrists for their willingness to consider excessive alcoholism as only a precipitating factor of alcoholic psychosis or an escape mechanism. He positively asserts that in 20 per cent of the 89,190 admissions, alcoholism was causative. But his proofs do not seem to be convincing. Scientific accuracy demands that careful analysis of the exact role of alcoholism be made each time it appears in the history of the disordered personality.

SUMMARY OF ALLEGED "CAUSES" OF MENTAL DISORDERS

Among the "causes" which are supposed to produce mental disorders are such factors as age, sex, puberty, adolescence, childbirth, menopause, race, climate, toxic agents, infections, physical disease, endocrine life, cultural status, heredity, psychobiological reaction types, acquired predisposition, domestic relations, fear, and anger.

By way of comment, it should be noted that virtually every normal human being encounters in his lifetime one or more of these "causes." Yet the percentage of abnormalities resulting from these encounters is relatively small. If the above-named elements were truly "causes" this selective factor would defy explanation.

The "Outline of Neuropsychiatry in Aviation Medicine," in discussing general causes, says: "These may be classed as the so-called exciting causes and include such factors as age, sex, physiological epochs, environmental conditions, climate, civilization, toxemias, bodily diseases, head traumas, physical and mental exhaustion, and emotional stresses. These are stresses common to all mankind. The mentally fit survive, while the mentally unfit make adjustments on levels increasingly lower until the state of a definite psychosis is reached, depending upon the degree of constitutional defects and the severity of the precipitant."³

FOOTNOTES

1. William Lyon Phelps, *Marriage* (New York: E. P. Dutton & Co., 1941), pp. 14-15.
2. Neil Dayton, *New Facts on Mental Disorders* (Springfield, Ill.: Charles Thomas, 1940), Chap. V.

3. U. S. Army, "Outline of Neuropsychiatry in Aviation Medicine," *Technical Manual* 8-325 (Washington, D. C., 1940).

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SUMMARY OF ETIOLOGY

In the preceding chapters we have attempted to demonstrate that mental and emotional disorders are not due primarily to diseased tissue or disordered function, but to the conscious or unconscious (marginal) employment of disturbed or pathological mental, emotional, or volitional habits for the purpose of avoiding reality situations or for the protection of the ego. Although we have discussed these habits separately for the sake of clarity they usually overlap and it is seldom that any one of them would occur in pure culture. These pathological habits arise when the individual is confronted by a situation or conflict which he recoils from facing realistically.

In order to understand this viewpoint, a careful distinction should be made between the *symptoms* and *signs* of disease processes. *A symptom is a subjective manifestation of disease, i.e., one which the patient can recognize for himself. The variety of symptoms is very great, and they differ from one patient to another even in the presence of the same underlying organic pathology. The emotional or mental symptoms are based on the personality of the patient and have no constant relation to any underlying physical pathology. A sign is an objective manifestation of disease and is based on the physical disturbance of an organ. For example, in paresis (parenchymatous syphilis of the brain) there are certain objective manifestations—the spinal fluid changes, for instance, which are constant. The symptoms, however, are extremely variable, and many symptomatic groups are described. It is in respect to these mental and emotional features of the disorder that we maintain a psychogenic etiology.*

The onset of these mental disorders may be acute or chronic. The development of a mental or emotional disorder, such as has been described, is usually slow and results from repeated small traumata. This is usually the case in civilian practice. Under unusual circumstances, for example, during wartime where the individual is exposed to overwhelming trauma, his defenses may collapse and an acute neurosis or psychosis may develop. The prognosis in these cases is

usually better than in those cases where the difficulty has developed over a long period of time. The mental tortures imposed on certain individuals as, for example, those imposed on Cardinal Mindszenty constitute such an overwhelming force that it undoubtedly explains the mental breakdown of individuals who had apparently been well integrated.

The onset of mental disorders may be in childhood but may be delayed until adult life. The defective use of the intellect, the emotions, or the will may begin at any time. More usually, the individual is exposed in childhood to the first traumatic events. It may be then that he willingly accepts the protective devices and finds comfort as they bolster his defenses. Their use may be discontinued after this for a long time, but the foundation has been laid and, when the individual is confronted later in life with a similar situation, he reactivates these defenses, retreats, as it were, to previously prepared defenses. On the other hand, the first use of these mechanisms may occur in adult life. It is our belief that the individual at first willingly accepts these various devices for avoiding painful reality; these reactions, however, soon become habitual and are adopted as a way of life.

There has been no satisfactory evidence that any mental or emotional disorder is transmitted by heredity.

DIVERSITY OF PSYCHOGENIC MENTAL DISORDERS

One of the problems of psychiatry is the explanation of the diversity of psychogenic mental disorders: for example, we have the neuroses, schizophrenic reactions, a great variety of manic-depressive pictures, and paranoia. Why do people become one and not the other? What factor or group of factors determines the type of disorder the patient will manifest? Kraines¹ feels that this differentiation is due to inherited constitution and to the innate make-up of the individual as modified by environment rather than exclusively to the forces of the environment. Most such explanations of the problem of diversity are tinged with a materialistic emphasis. But, in spite of this prejudgment, it is not difficult for the modern student to realize that (a) there are numerous clinical variations of mental disorder; (b) a great number of factors contribute to the production of mental disorder; (c) basically there are very few real causal factors; and (d) the particular environmental setup is largely responsible for differentiation.

There is no certain body of knowledge on the subject, but after careful summary and evaluating of the various probable opinions which have been proposed, the following explanation seems to be the most acceptable. The type of psychogenic mental disorder that ultimately develops in cases is due principally to one or more of these forces:

1. The development of undesirable habits of thinking, feeling, and willing,
2. Defective home training,
3. Environmental influences.

All of these important factors separately considered are highly variable. Combined, this variability is greatly increased. The resultant combination of forces is never the same in any two cases. The effects on personality are never the same. Thus an individual employing erroneous and undesirable psychological escapes from reality is at the beginning of his disordered career potentially a schizophrenic, manic-depressive, paranoiac, or neurotic. Of ten individuals born into this world, none are destined to a life of psychic maladjustment. All may be submitted to substantially the same trials. Five may face them frontally, readjust themselves properly, and develop into five different types of normal being. The other five will react erroneously to their problems and be subsequently maladjusted. One may become a schizophrenic, another a paranoiac, a third may develop a profound mental depression, and the others may become neurasthenics or hysterics.

SUMMARY OF THE PHILOSOPHICAL BASIS OF ETIOLOGY

In a treatise such as this is, it is neither possible nor necessary to give the entire philosophical doctrine on potency and act, on matter and form, and on the union of soul and body. Some previous knowledge of such doctrine is, however, a prerequisite for a proper understanding of psychiatry. It is desirable, therefore, to review briefly a few conclusions from metaphysics and psychology. These will be helpful for the correct understanding of the philosophical basis of such psychic activities as the begetting of ideas, judging, reasoning, the nature of the emotions and complexes, the nature of sensation and similar psychic activities. The following points are considered most important:

- a) *Living and nonliving beings differ radically* in that living beings have immanent action which is displayed in growth, repair, reproduction, and intrinsic finality.

b) *Man lives and has a body and soul. The soul or vital principle of man is simple, substantial, spiritual, immortal, and one.* The soul is substantially united to the body and with it forms one essence, one nature, and one person.

c) *Man has cognitive powers* which give him both sense and rational knowledge, as well as *an appetitive power* with both sensory and rational tendencies. Under certain conditions the rational will enjoys freedom and is able under such circumstances to exercise choice.

d) *Because of the substantial union of soul and body*, man is a perfect unit and *all activity must be attributed to the whole man* thus composed by the substantial union of soul and body. This is what is meant when it is said that actions belong to, or flow from, or are produced or caused by, *the supposit*. A *supposit* is defined as a being existing of its own right, for example, a tree, a beast, and a man. If the being subsists with a rational nature it is known as a person. Mercier, discussing the axiom of the Schools, "*actiones sunt suppositorum*," observes: "We never predicate activity of an accident or of a part of a substance; we always assign the efficient cause of a thing to a subject that exists in itself."² The same notion is conveyed by Renard: ". . . This knowledge is precisely the knowledge of man, because man is an *unum per se*, composed of essence and 'to be,' of body and soul, of substance and accident. He is a perfect unit because all these distinct realities are not independent beings, but as integrated parts, are transcendently ordered to form a subject that is strictly one. It is, then, because of the perfect unity of this being that Thomas repeatedly insists: It is not the eye that sees, neither is it the hand that feels, nor even the soul that understands, but we must say that man himself 'sees with the eye, feels with the hand, understands through the soul.'"³ *The supposit is therefore the principle which acts.* This is often referred to as the *principium quod* of all activity. The nature is the principle *by which* the supposit acts and nature is therefore called the *principium quo*. *The intellect is frequently referred to as the faculty of thought. A faculty is defined as the immediate principle of action.* Coffey⁴ presents the matter of causality clearly as follows: "Finally, we must distinguish between the *individual agent* itself as cause (the *suppositum* or person that acts); the agent's *nature* and *active power* as causes; and the *action* or exercise of this power as cause. The former, the individual, concrete agent, is the '*principium quod agit*,' and is called the '*causa ut quae*.' The nature and the active power of the agent are each

a 'principium *quo* agens agit,' the remote and the proximate principle of action respectively; and each is called a '*causa ut qua*.'"

Glenn summarizes the true doctrine on the mutual influence of body and soul in man as follows:

1. The soul influences the body formally and gives it its being and its capacity for vital operation. This is certain because the soul is the substantial form of the body: it is "the first act of the physical organic body."

2. The body acts materially with the soul, or influences the soul materially, inasmuch as it concurs with the soul, or suffers the soul-action, in establishing human nature.

3. Once substantially united, soul and body exercise a mutual influence. The soul is the root-principle of all the vital operations in man, vegetal, sentient, rational. A vegetal disorder, for instance, can impede rational activity; a mental derangement can have an effect upon the organism; and it is commonplace that when a man's bodily condition is what it should be, when he is "in the pink of condition," he can do his best mental or rational work. Conversely, — as any nurse or doctor can testify, — the freedom of the mind from worry or distress is a tremendous aid in restoring proper bodily functions, and in helping the body to react properly to the treatment which aims to restore its integrity and power.

4. The influence of soul upon body is physical and direct; it is what philosophers call a physical *per se* influence. The influence of body upon soul is physical, but not direct or *per se*. For the body has, in itself, no power of direct influence except in the quantitative relation; the body *per se* is not active but passive. It is the soul that is the seat of vital activity in bodily man.

Hence, while there is unquestionably an influence working from body to soul, the body, to exercise such influence, must first be alive, must first be vitalized by the soul. In the last analysis, it is the soul which is the root-source of bodily activity, even of such as turns its influence back upon the soul. As Fr. Lortie remarks, — in his *Elementa Philosophiae Christianae*, — "it would be truer to say that the soul acts on itself through the mediation of the body" than to say that the body acts on the soul.⁵

e) *Sense knowledge is begotten* not by the soul alone nor by the body alone, but *by the animated organism*.

f) *Rational knowledge or intellectual knowledge is "the operation proper to the soul of man."* Renard⁶ continues, "This operation is a spiritual act. It is performed without a corporeal organ. Never-

theless, it depends upon matter, inasmuch as *matter* is a necessary condition for the 'to act' of the intellect." (See Maher under *h*.)

g) The Scholastic explanation of the origin of ideas is presented by Maher as follows:

An object produces an impression on a sensitive faculty. This results in a sensuous phantasm in the imagination, and here the work of the lower power ends. Since, however, in man the sensuous faculties of cognition have their source in a soul also endowed with intellectual aptitudes, the latter now issue into action. The presence of the phantasm forms the condition of rational activity, and the intellect abstracts the essence; that is, by its own active and passive capabilities generates the concept which expresses in the abstract the essence of the object. By a further reflective act it views this abstract concept as capable of representing any member of the class, and thus constitutes it a formally universal idea.⁷

h) Maher emphasizes the activity of the intellect in the begetting of rational knowledge and its dependence on the body as upon a condition. He says:

In asserting that the intellect is a spiritual faculty, we do not of course imply that it is in no way dependent on the organism, any more than in maintaining the freedom of the will we suppose this latter faculty to be uninfluenced by sensitive appetite. It is indisputable that exhaustion of brain power accompanies the work of thinking; but the fact that the exercise of imagination or of external sense forms a *conditio sine qua non* of intellectual activity, accounts for such consumption of cerebral energy. Although intellect is a spiritual faculty of the mind, it presupposes, so long as the soul informs the body, the stimulation of the organic faculty of sense. This was expressed in the language of the schools by saying that intellectual activity depends *extrinsically* or *per accidens* on the organic faculties. The universal concept, the intellectual judgment, the act of reflexion, are not, like sensation, the results of the stimulation of a sense-organ, but products of purely spiritual action. The inferior mode of mental life is awakened by the irritation of sentient nerves, the superior activity is due to a higher reaction from the unexhausted nature of the mind itself; and the ground for this reaction lies in the fact that the same indivisible soul is the root of both orders of faculties. Intellectual cognition always involves *self-action* on the part of the mind, but the conditions of such self-action are posited by impressions in the inferior recipient faculties.⁸

The above principles, we believe, adequately prove the nature of the union of soul and body as well as the causality of

psychic activity. The fact that the soul and body are substantially united and establish man as a unit exclude all other opinions as to man's constitution, for example, Platonism, Cartesianism, or any similar theory.

Since man is composed of body and soul, he experiences feelings and emotions. The man who preserves permanent psychic balance has trained himself from his earliest years to follow reason in his choices and has, therefore, developed sound principles, ideals, and character. He has subordinated feelings, impulses, emotions, and complexes to intelligence. He meets life's problems realistically and has for them an adequate solution. In this way, he preserves permanent mental strength.

This is an ideal which men may keep before them and, according to their ability and training, strive to establish in their lives.

This is our view on the nature of man and it is perhaps important, in our conclusion, to emphasize that in this view man is a substantial unity. This is the strictest unity of which we have any knowledge. It means that body alone and soul alone are incomplete substances, designed by their very nature to complement and supplement each other and by their union to form the one complete substance, man.

In this view, and in this view alone, there is no mind-body problem. Mind and body are both essential elements of the being in question. The view of man's essence and activity thus presented makes man one living unity, without sacrificing the duality of body and soul. For psychiatry this is an immense advantage; it is the only viewpoint which makes possible a satisfactory explanation of the mutual influence of mind on body and body on mind which is so important for the adequate understanding of psychiatric concepts.

FOOTNOTES

1. S. Kraines, *Therapy of the Psychoses and the Neuroses*, 2 ed. (Philadelphia: Lea and Febiger, 1943), p. 23.
2. Cardinal Mercier, *A Manual of Modern Scholastic Philosophy*, trans. by T. L. Parker and S. A. Parker, 8 English ed. (St. Louis: B. Herder Book Co., 1916), Vol. I, p. 485.
3. Henri Renard, *The Philosophy of Being*, 2 ed. (Milwaukee: The Bruce Publishing Co., 1946), p. 2.
4. Peter Coffey, *Ontology* (New York: Peter Smith, 1938), p. 379.
5. Paul J. Glenn, *Psychology* (St. Louis: B. Herder Book Co., 1946), p. 230.
6. Renard, *op. cit.*, p. 41.
7. Michael Maher, *Psychology, Empirical and Rational* (London: Longmans, Green & Co., 1921), p. 311.
8. Maher, *op. cit.*, pp. 241-242.

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PART III

CLINICAL APPROACH TO PSYCHIATRY

C H A P T E R

XIV. THE PSYCHIATRIC HISTORY

XV. THE MENTAL EXAMINATION

THE PSYCHIATRIC HISTORY

The fruitful examination of psychiatric patients is a very difficult art. It is impossible to give a complete set of instructions to guide the student. The best and only teacher is experience. The principal obstacles to the formulation of thumb rules of diagnosis and patient examination are the great diversity of psychiatric pictures, the extreme sensitivity of the patient, and the recondite nature of neurosis and symptom purposefulness.

The following suggestions will be of assistance in history taking:

1. The patient should be allowed to tell his complete story just as he sees it.

2. This will ordinarily require several interviews on different days. Study carefully the feeling of the patient, his attitude toward the examination and any special psychic peculiarities. Notes should be made of what is seen, as well as what is heard.

3. No attempt should be made to make a diagnosis before complete data have been obtained.

4. The investigation should be conducted as leisurely as circumstances permit. The patient must not get the idea that he is being rushed through. The examination is best conducted in private.

5. The patient should be encouraged to discuss even those symptoms which to him may seem "silly." Approach the patient as an adult. Avoid any appearance of reproach, ridicule, or argument.

6. Especial importance should be attached to anything which directly or indirectly throws light on the purposefulness of the neurotic state. Record any unusual statements of the patient verbatim. Follow up leads given by the patient which appear to be "slips of the tongue."

7. During the examination, no effort should be made to give an interpretation or partial diagnosis.

8. The important thing is that the patient become aware of the sympathetic interest of the examiner and that a feeling of confidence be aroused. Make the patient feel that you want to help.

9. Avoid as much as possible writing notes in front of the patient.
10. A thorough physical examination should be made in an unimpressive, careful manner. As much as possible, no noticeable emphasis should be given to any phase of the examination lest the patient become unnecessarily alarmed.

The physician or psychiatrist who would be of assistance to a mentally disturbed patient must make every effort to obtain all possible information. These data must be available to all those who would understand and aid the mentally ill. All students, even those who are interested in merely academic knowledge, will profit by an understanding of what data should be obtained and how to get it.

The methods used in the examination of the psychiatric patient are no different from those used in other medical examinations, but the emphasis is placed in another direction. In the usual medical history, the attention of the examiner is directed toward the patient's somatic complaint, whereas, in the psychiatric history, emphasis is placed upon environmental influences and psychic manifestations.

THE PSYCHOSOMATIC HISTORY

Actually, the psychosomatic approach to diagnostic problems is nothing new. It was the approach of the old family doctor. He was able to utilize the knowledge which he acquired by his frequent and intimate contacts with his patients to obtain the type of historical data which is such an essential part of the psychosomatic anamnesis. His patients grew up, loved, married, and died under his watchful eye; what he himself missed was retailed to him over the dinner table by his ubiquitous wife. When medical practice became more specialized, and the pathological basis of disease became better known, the intimate facts of the personal lives of patients became of less interest to the doctor. Greater stress was laid on the mechanical means of diagnosis and, although the history of the case was by no means neglected, it was evaluated almost exclusively in terms of organic pathology. The past history was considered important only for the medical facts it contained. Little attention was paid to the patient's loves and hates, his family problems, his financial stresses, or his fears and anxieties. The clinician was then, as he is too frequently still, impatient over these "irrelevant details."

In the "mechanical stage" of medicine every effort was made to explain the symptoms on an organic basis. The doctor felt that unless his tests revealed some organic pathology he was missing

something. There was then, as there is now, a tendency to diagnose a functional disturbance by the exclusion of organic disease. This is usually impossible because one cannot exclude every possible organic disturbance by current diagnostic procedures.

A new orientation toward functional disturbances is necessary. Too many physicians feel incapable of handling "neurotic" patients, and many others are inclined to treat their problems as "imaginary." They tell the patient there is nothing wrong with him and to go home and "forget it." To the patient and to anyone who understands psychogenic disorders, this is improper advice. The patient knows that he is suffering and that such suffering is not purely imaginary, even if the doctor cannot find the cause of it.

Every patient has a psychogenic element to his illness, even those who have basically physical or organic illnesses. This is due to fear concerning the outcome of the illness and the feelings of insecurity which it engenders. About one third of the patients who seek treatment have psychogenic disturbances for which there is no organic pathology, although there may be a disturbed physiology. Another one third have some underlying pathology, but have also a marked psychogenic component. In this group might be placed a great many of the diseases usually thought of as organic, such as essential hypertension, asthma, ulcerative colitis, and migraine, in which psychogenic factors play a large role. This holds true not only in etiology, but also in treatment. The remaining one third is the group of patients mentioned above, in whom organic disease is present and definite, but in whom fear and insecurity produce symptoms of their own.

There is nothing new in the psychosomatic approach to disease. Actually, it is a return to the day when the doctor was a friend, in a real sense, to his patients. The psychosomatically minded physician is interested in those environmental influences which are likely to have produced his patient's symptoms. The psychiatrist goes further than this and seeks the motivating forces and underlying psychopathology. One does not have to be a psychiatrist to practice good psychosomatic medicine.

The ordinary medical history is deficient in many ways. From the psychosomatic standpoint it gives only half of the picture. From this viewpoint, it is necessary to know as much as possible about the environmental factors which were influencing the patient while he was experiencing his symptoms. The following case history exemplifies the deficiencies of even a well-taken history:

CASE 12: *Example of Typical Case History*

Chief Complaint: (1) weakness; (2) epigastric pain; (3) excessive "gas."

In May, 1945, the patient had a "virus" infection of the throat and subsequently developed whooping cough. The constant cough caused her much distress and general debilitation. She recovered from the pertussis, but her general condition did not return to normal. In subsequent weeks she developed numerous pains, chief among which was a rather constant epigastric discomfort. She experienced this especially after meals, and thought it was "indigestion." The pain was not acute, but of a dull continuous nature and radiated along the right costal margin to the back. Occasionally it extended to the right breast. This had been diagnosed as gall bladder colic and surgery had been advised in spite of negative X-ray findings. She belched frequently and expelled gas. At times she had vague pains in her lower abdomen and a feeling of "tightness." Her bowels moved only with the aid of laxatives and only with considerable difficulty.

Her appetite had waned and she had been eating chiefly bland foods. Fats, pork, cream, ice cream, cabbage, and sweets disagreed with her. Her eating habits were regular, but she believed her intake was not adequate. In the past few weeks she had experienced a burning or "stinging" sensation on urination and stated that she was incontinent at times. An examination of her urine at one time revealed "blood and pus," but a repeat examination was negative. She described intermittent lumbar and low pelvic pain and stated that her "kidneys had been weak lately." On some occasions she had a feeling of oppression in the vicinity of her heart, not promoted by exercise. She had periodic episodes of coughing and a "drying sensation" in her throat. Generalized muscular pains which had been present of late contributed to her general debility.

She has felt considerably better in the past twenty-four hours. The day prior to admission she felt "nauseated and ill" and had a "peculiar" pain in her back. She drank a considerable quantity of water, then experienced a "sort of snapping sensation in her back," after which she felt much better.

Past history revealed the usual childhood diseases. There were no major illnesses. She was in an automobile accident many years ago in which she received multiple injuries, chiefly involving the right side. Five years ago, she was operated on for removal of a fibroid uterus and a chronic appendix. Physical examination was essentially negative, except for hyperesthesia of the breasts. There was

a moderately firm, irregular mass palpable in the right breast. This was not clearly defined and may have represented breast tissue with fibrosis. The left breast was normal and no masses were palpable. There was tenderness in the epigastrium and right upper quadrant.

This history was written by the resident and is a good example of the facts usually elicited by the medical history. The environmental or psychosomatic history in this case establishes a new viewpoint and casts a new light on the nature of the patient's symptoms. The patient with a slight encouragement gave the following additional history:

She had been very unhappy about coming to this country, having immigrated to America at the age of ten. This, however, seemed to have little to do with her symptoms, because as far back as she could remember she reacted to emotional disturbances with gastrointestinal symptoms. It had always been her ambition to be a singer and when she was twenty she began to take singing lessons from a woman teacher "who was rather eccentric; she insisted on putting her arms around me and handling me while she was teaching." Her experience with this homosexual instructor finally became unbearable and she gave up her lessons, but only after marked conflict because she felt that in doing so she was renouncing her career.

At a somewhat later period she fell in love with a chronic alcoholic with whom, in spite of a very strict religious conscience, she had sexual intercourse in an effort to reform him. This effort failed after several years and she gave up this man.

She fell in love again with a man whom she had met at a party and who displayed interest in her. Her advancing years made attention desirable inasmuch as she had always retained the desire to get married. This man was insistent on sexual relations to which she again consented, although reluctantly. Again her conscience began to plague her and she soon broke off this relationship.

Her feelings of guilt in this instance were more severe and she developed in addition to her digestive disturbances (which resulted in the above hospitalization) many prepsychotic manifestations. Among these she expressed ideas of influence. "He had a hypnotic power: he was able to put his thoughts into my mind and I was unable to help myself." She also expressed ideas of reference. "He told everybody about me; people used to turn and look at me; he would be everywhere."

After a thorough examination, in which no organic pathology was discovered, the patient was given psychotherapy, became symptom free, and developed good insight.

A more thorough investigation of environmental factors and the personality of a patient pays dividends not only for the therapist, who will thus be able to make more accurate diagnoses, but also for the patient, who will be spared unnecessary treatments and surgical procedures.

To those who ask for a systematic approach to the psychosomatic history, there is no definite answer. There is no brief, quick question and answer form. By changing the focus somewhat in the ordinary medical history, much useful information may be obtained. The ordinary concentration is on symptoms; the psychosomatic interest is on environmental influences which were affecting the patient while he was having his symptoms. If this is borne in mind while the ordinary form of the medical history is being used, an entirely different result may be obtained. Experience has taught that "the greater our success in switching the conversation from symptoms to personal affairs, the sooner do we come into possession of the real problems disturbing the patient."

In taking the family history, it is not sufficient to inquire into the causes of death of the father and mother, the grandparents, and others. It is important to ask whether or not anyone else in the family had similar symptoms; whether or not they resemble one of their parents; how many siblings there were. If the parents are dead, were they present during the last illness; did they nurse them; did they have to watch the suffering of their loved ones? Ask about intrafamily relationships. Did they get along well with their parents and siblings? Other questions affecting family relationships will be suggested by answers to the above and may give valuable clues to the symptoms and problems of the patient.

The psychosomatic history puts less emphasis on the usually elicited medical facts and inquires into factors and circumstances which may help to explain them. The following case history exemplifies this point of view:

CASE 13: *History Exemplifying Psychosomatic Factors*

A white female, 26 years of age, had been referred for study because she had several severe attacks of right-sided abdominal pain. Past history was taken in the usual manner and revealed only that she had had several previous attacks of the same nature. On one occasion following a cystoscopy, a diagnosis of ureteral calculus was made. She had been discharged from the Waves because of

frequent fainting spells. If the physician had been satisfied with this usual type of history, he would undoubtedly have been satisfied that the trouble was urinary in origin. A psychosomatic history, however, revealed much valuable data:

She was an only child of parents who were constantly at odds with each other. Her mother was a cardiac invalid for a great many years and the patient was required constantly to attend her. From early childhood she had had a marked tendency toward kleptomania and pathologic lying. At the age of fifteen it was her father's custom to send her to the bank once a week with money to pay off a loan. She regularly appropriated this money for her own use and when the bank began to send notices of nonpayment, she went to the president of the bank and told him the truth about taking the money, but stated that she had used it to help out one of her friends who was illegitimately pregnant. Upon receiving the promise of the bank president that he would give her a month to pay back the money, she secured the necessary amount from a variety of boy friends.

She had been brought up as a Catholic, but in spite of the fact that she was supposed to fast before going to Communion, she made a regular practice of eating breakfast. She had no explanation for doing this, except that she thought it was fun to fool the Sisters. She developed the practice early in life of becoming sick or fainting whenever she did not get her own way. In this way she tended to identify herself with her mother who had her worst "heart spells" when her husband would start an argument. This practice of fainting continued with increasing frequency and after entry into the Waves it was employed with such frequency that she was finally admitted to the hospital and discharged medically because of them.

At the insistence of her father she married a man somewhat older than herself with whom she did not make a good adjustment and during his absence at work she had a number of love affairs with other men.

After divorcing her husband, she accepted employment in a government bureau, but after a year she was asked to resign because of her promiscuity with the male employees. According to her own statement, she spent each week end with a different man. After leaving this employment, she entered the Waves and continued to spend each week end with a different man. During this entire promiscuous period she was sexually frigid in her heterosexual relations, but continued to masturbate at quite frequent intervals. During this period she also had a number of homosexual fantasies.

During her period in the Navy she fell in love with a junior officer who would not marry her at first, but she insisted on a trial period of six months, "so I could make him love me." She married this officer and began to be plagued with feelings of guilt concerning her past. During this period, in spite of her frequent heterosexual relations, she continued to masturbate.

There were other factors playing an important part in this case. It may be that her present symptoms were precipitated by the fact that she had discovered that some of her husband's friends were among her previous sexual companions and she was afraid of their revealing these facts to him. As a result of psychotherapy, stressing the development of more mature attitudes, the patient improved considerably.

If a systematic review is made of the influences affecting the individual during childhood, school life, employment, and his marital and sexual life, important information will be obtained. Many doctors feel that patients resent questions in regard to the intimate details of their personal lives. Generally this will not be the case if they take sufficient time and show the patient that they are interested in him personally and desirous of doing more for him than merely treating his symptoms. Many patients, when given the opportunity, will spontaneously reveal the cause of their symptoms. "I've never told any other doctor about this. They always seem to be in such a hurry and I didn't think it was important."

A great many psychosomatic difficulties arise over misunderstandings and ignorance in regard to sexual matters. There are many doctors who feel too much stress is laid on sex. There is no doubt that often this is true. It must be admitted, however, that sexual conflicts do play an important role in the genesis of functional disturbances. Too many doctors shun discussion of sex with their patients. This is very frequently due to their own ignorance of the importance of the matter and the feeling that the patient is reluctant to discuss it. The patient needs little encouragement and he will be grateful for the opportunity of discussing his sexual life with one who he thinks can help him. There is no special technique for eliciting these facts. Too blunt an approach will usually arouse a defensive attitude on the part of the patient. In women, a discussion of the menstrual history may be followed quite naturally by questions in regard to frigidity and then more intimate details. In men, in whom these difficulties are more frequent than is realized, bluntness is especially

contraindicated because of their male egotism which makes any remark that sounds like criticism of their sexual ability a matter of insult.

Exaggerated ideas of the importance of psychic difficulties may lead the clinician astray. The discovery of apparently important psychological disturbances may keep the diagnostician from sufficient investigation into the organic factors.

CASE 14: *Organic or Psychic Factors?*

A white female, 49 years of age, was admitted to the hospital complaining of pain in her chest. For two years prior to admission, she had moderately severe, frequent pains in the left chest anteriorly and a sensation of thoracic compression. The symptom was incited by activity such as standing while washing dishes or walking up steps. It was relieved by rest. She often woke up at night with attacks of pain. Dyspnea of moderate severity accompanied the attacks. Frequently the pain radiated to her back in the interscapular region. Nocturnal dyspnea was a less frequent but disturbing occurrence. Moderate indigestion, characterized by an intolerance of cabbage and meat (particularly liver and steak), was a frequent complaint. Physical examination was essentially negative.

The psychosomatic history revealed that for the past two years she had had two sons in the service. One of them had written regularly and had returned home. The other wrote irregularly and was married while in the service. The patient had not seen her daughter-in-law, but had written to her frequently. She had had no answer to her letters and did not know the whereabouts of her son. She became overemotional while discussing this matter and was considerably relieved afterward. "He was such a good boy. It is not like him to act like this." X-ray examination showed a large number of stones in the gall bladder, leaving for the clinician the decision as to how large a part the psychogenic factors played in the symptomatology. Her response to psychotherapy was so good that it was decided to leave the gall bladder in place.

It should again be emphasized that there is no routine method of eliciting the psychosomatic history. If the patient is given a chance he will usually tell what is wrong with him. More time in history taking will save many unnecessary procedures. The surgeon cannot remove a pain of psychogenic origin, nor can the roentgenologist see it on his films; but the psychosomatically minded physician can detect it by painstaking attention to details of the history.

AN OUTLINE IS ESSENTIAL

Some form of outline is essential for an orderly recording of the data obtained from the examination. A variety of forms have been proposed, but most of them are too detailed and cumbersome. The outline should be as brief as possible and should provide merely paragraph titles. This sort of outline gives greater latitude to the individuality of the examiner. It is extremely important that the history as recorded should contain the information given by the patient and not the examiner's interpretation of that information. Interpretation should follow examination, not be a part of it.

There is no single approved method of examination. The type of investigation will depend on the nature of the patient's disorder, his accessibility and the degree of rapport which can be established. Experience alone is the best teacher.

Some patients who are reluctant to discuss their problems because of self-consciousness may frequently be persuaded to write out their history, a task which many of them perform in an excellent, clear manner which displays considerable insight.

THE DIRECT EXAMINATION

The direct examination of the patient consists essentially of a review of his past medical and social background. This should be obtained in as complete and orderly a fashion as the mental condition of the patient permits. Confirmation of the history from a reliable informant, preferably a near relative, is not only helpful, but will frequently reveal information which throws a new light on the situation.

The direct examination should be recorded under the following headings, which should also be used as an outline in the history taking so that no important facts will be omitted:

1. Chief complaint
2. Present illness
3. Past history
 - a) Birth and infancy
 - b) Early development
 - c) Home environment
 - d) Education
 - e) Industrial history
 - f) Medical history

- g) Habits
 - h) Sex life
 - i) Mental history
 - j) Social adjustment
4. Family history

The reason for such topical distribution is obvious. The chief complaint is best recorded in the patient's own words. The present illness deals with the development of the patient's present mental illness and describes in detail the development of the chief complaint. Some tests attempt to give specific questions to be asked in regard to the history. These are of little value and tend to produce a certain stiffness of attitude on the part of the examiner which handicaps the examination. The aim is to get as much pertinent information as possible. Direct questions are frequently answered in the negative. An indirect approach with descriptive terms will elicit such information denied by more direct methods. If the examiner convinces his patient that he has a genuine interest in him and helps him along with guiding suggestions, the complete history will be obtained with little trouble in most cases.

CONCLUSION

A history is only as good as the information it contains. Form is important but the facts are more important. Therefore, keep in mind this important consideration and at every opportunity practice history taking. Good history writing can be acquired only with practice.

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THE MENTAL EXAMINATION

The *indirect*, or *mental*, part of the psychiatric examination is usually recorded under the following titles:

1. General appearance and attitude
2. Orientation
3. Sensorium and intellectual factors
4. Psychomotor activity
5. Memory
6. Stream of thought as displayed in speech and writing
7. Content of thought: (*a*) delusions, (*b*) hallucinations
8. Emotional reaction, mood, complexes
9. General knowledge
10. Calculation ability
11. Judgment
12. Insight
13. Ethical questions
14. Intelligence tests
15. Projection tests

In the succeeding pages the above points will be discussed in detail.

GENERAL APPEARANCE AND ATTITUDE

The ability to observe is poorly developed in most people. It is a faculty, however, that persistence in observation will develop. A student confronted by a patient in stupor frequently feels quite helpless in the conduct of the examination, inasmuch as the usual source from which he obtains his information, i.e., the history from the patient, is taken away from him. Careful observation, even in such a case, will however reveal enough information to make a tentative diagnosis possible, or at least point the way for further studies.

Prior to the first interview with the patient, it is prudent to inspect the admitting sheets of the hospitalized patient and thence glean some of the salient features of the case. Data may also be secured from the relatives, nurses, and attendants as to his attitude in the

wards, and the degree of co-operation or resistance toward physicians and nurses. Is he resistive, evasive, irritable, apathetic, compliant?

When one is first confronted with a patient, special note should be made of his general appearance, degree of ease, facial expression, condition of dress, and attitude.

No attempt will be made in this chapter to relate any symptom to a particular clinical syndrome. It is better at this point to have in mind the symptomatology of mental disease in general so that the terminology can be understood as it comes up in the discussion of cases.

ORIENTATION

Orientation for time, place, persons. Does the patient know date, month, season, year, hospital's location, name, and nature? Identification of nurses, doctors, attendants, and patients.

SENSORIUM AND INTELLECTUAL REACTIONS

Careful investigation in this field is essential to prevent frequent mistakes. Sensory defects are particularly common in organic disturbances. The following is a brief outline which should be considered a minimum for this part of the examination:

Attention

Disturbances of consciousness have already been discussed in previous paragraphs. Special attention should be paid to the patient's ability to maintain his attention on the subject until the discussion is complete. Disturbances of the attention are usually discussed under the following headings:

1. *Fluctuation of the attention.* This is a common manifestation in the somatopsychic type of reaction and manifests itself by a waning of interest on the part of the patient. Although he seems to lose interest, he may himself bring up the subject at a later time.
2. *Aprosexia.* This term refers to the inability of the patient to fix or hold his attention on a subject.
3. *Hyperprosexia*, or excessive preoccupation.
4. *Blunting of attention.* In many conditions, a gradually increasing strength of stimulation is necessary before a response can be obtained. This is especially the case in the presence of clouding of consciousness, such as is frequently present in stuporous states.
5. *Clouding of consciousness* is a disturbance in which the patient

is not completely clear in his mind. It occurs most frequently as a result of organic disturbance in the central nervous system. His threshold of stimulation is high so that stimuli of unusual strength are required to produce clear sensory perceptions. For this reason, the patient appears "slowed up" and it may be necessary to shake him or raise the voice to obtain his attention. As a general rule, he pays little attention to his environment.

6. *Confusion*. This is usually associated with the facial expressions of perplexity, bewilderment, or surprise. The patient grasps things slowly, is frequently disoriented, and feels within himself the perplexity and bewilderment expressed on his face. He associates poorly and thinks slowly. True confusion is usually found only in the somatopsychic reactions.

PSYCHOMOTOR ACTIVITY

The mind and body influence each other. All activity results from interaction of body and mind. It is not, however, easy, from the observation of activity, to say which of these agencies predominates, whether undue glandular activity stimulates the mind or extreme mental activity perturbs the body. These activities may take an indefinite number of forms, of which the following are samples:

1. *Overactivity* (increased psychomotor activity). Overactivity consists of a rapid succession of acts. It is frequently seen in the excited (manic) phases of the manic-depressive psychosis. The activity of both body and mind seem to be accelerated.

2. *Automatisms*. These are movements which the patient performs without self-criticism when they are suggested to him. They may consist of the imitation of the movement of the examiner (echo-praxia) or an imitation of the words of the examiner (echolalia).

3. *Stereotypy*. This consists of a constant repetition of the same movement and attitude or words. The patient once started may repeat the same words constantly, day in and day out for long periods of time.

4. *Tics or habit spasms*. These consist of a frequently repeated, co-ordinated contraction of a group of muscles. They usually become more marked under conditions of stress.

5. *Negativism*. This consists of an automatic muscular resistiveness to the motor manipulations by the examiner. Very frequently the response is the opposite to that usually elicited or desired.

6. *Mannerisms*. These are bizarre repetitive movements, usually fre-

quently repeated. They are usually in keeping with the personality of the patient.

7. *Catalepsy*. In this condition the patient is able to maintain fixed posture of the body or parts of it for long periods of time without any evidence of muscular effort or fatigue. In extreme forms of this condition the patient maintains the posture for long periods even though he is placed in an awkward position. In this extreme degree, this condition is usually referred to as *flexibilitas cerea* (waxy flexibility).

8. *Stupor*. In this condition the patient cannot be aroused except by strong stimuli. It may vary in degree from lethargy to deep coma. It differs from the coma of organic disease inasmuch as there is little apparent disturbance of somatic function.

9. *Impulses*. These consist of sudden outbursts of activity, without apparent deliberation, in a patient who is otherwise relatively inactive. It is obvious, however, that they are the outcome of a preceding period of unrest.

10. *Perseveration of movement*. This term is usually used to refer to the continuation of a movement in spite of the patient's effort to produce a new movement and in this respect differs from stereotypy.

11. *Compulsions*. These are acts which the patient feels compelled to perform as a result of obsessive ideas.

Summary of Special Types of Psychomotor Behavior

Smiling or laughing without apparent cause; hilarious, elated, hyperactive, shouting, talking, or whispering to self or to an imaginary person; talking at a rapid rate; talking little; silent, uncommunicative, hypoactive, inert, stuporous; gesturing; tics; grimacing; mannerisms; attitudinizing; stereotypy; waxy flexibility; excitement; agitation; profound depression; attempting to harm self; suicidal attempts; echolalia; echopraxia; unnatural sex conduct; loss of acquired refined habits; change from refined to coarse behavior.

MEMORY

Memory should be tested separately for recent and remote events.

Remote Memory: Question concerning the following:

Date and place of birth.

Events of earlier life.

Schooling, marriage, business or occupations.

Travel. Knowledge of world history.

Recent Memory: Where do you live?
 What is your home address?
 How long have you been here?
 What of interest did you read recently in the
 papers?
 What did you have for dinner?
 What did you do yesterday?

Recent memory should be examined by a series of questions concerning recent happenings, such as "Where is your home?" "What did you have for breakfast?" "When did you come to the hospital?" Remote memory deals with matters of the past and may be checked against available statistical data. Such questions as these should be asked: "Where were you born?" "What is the date of your birth?" "How old does that make you?" "Are you married?" "What is your wife's maiden name?"

1. *Amnesia* is a gap of memory involving a limited span of time.
 2. *Hyperamnesia* is excessive retention of memories.
 3. *Paramnesia* or confabulation is the recollection of events which did not happen.
 4. *Retention and recall.* To test retention the patient may be given a name, an address, or an object and asked to recall it after five minutes, an hour, or a day.
- Another method of immediate recall is to ask the patient to repeat a series of digits.

Repeat forward

68327
 945753
 3289725
 47825864

Repeat backward

5736
 72398
 579426

STREAM OF THOUGHT AS DISPLAYED IN SPEECH OR WRITING

Speech, writing, and various other signs express the ideas and judgments of the individual. If the expression be rapid and flighty or slow and psychically rooted or stagnant, it may be concluded that the stream of thought is of a similar nature.

Quantity of Thought

Variations in the stream of speech may be of many kinds and are quite common as evidence of a psychiatric disorder. The following changes are the most common:

1. *Increased production*, better known as *volubility*, is not in itself significant except as evidence of an extroverted personality, but is a common accompaniment of manic states. The stream of thought may be a rapid and ceaseless expression of ideas, with increased energy output, pressure of thought, spontaneity, flight of ideas, garrulousness, and volubility. Ideas may be vehemently expressed.

2. *Diminished production* is known as *poverty of thought* or lack of ideas. Thought is meager in amount and retarded in tempo. Weakness of expression may reach the extent of mutism.

Quality of Thought Stream

The following terms are descriptive of disturbances in this field:

1. Clear, logical, relevant, coherent, closeness of association of ideas, grasp of entirety. Thought stream well directed toward a goal. Spontaneous.

2. Confused, irrelevant, relation between ideas not apparent, lack of continuity, failure to follow an idea through to completion, distractibility, blocking of thought stream. Disordered, queer, jumbled, fragmentary, circumstantial.

3. Note the flow of speech: rapidity or slowness; coherence, relevance; ease or difficulty in answering questions. Note whether the patient seems preoccupied with his own thoughts, or attentive to the interviewer; also whether evasive or outspoken.

The following patterns, among others, manifest the stream of thought of the patient:

1. *Distractibility*. In this disturbance the patient changes frequently from his goal idea because of some chance sight, sound, or thought. As a rule, however, he eventually reaches the goal idea.

2. *Flight of ideas*. In this condition the degree of distractibility is so great that the patient never reaches the goal idea. His flow of speech is continuous but fragmentary with chance associations between the fragments.

3. *Circumstantiality*. The patient describes his symptoms with much detail, spontaneity, and volubility, but eventually reaches his goal idea.

4. *Verbigeration*. This consists of a flow of unconnected words, some of which are frequently repeated.

5. *Scattering, disconnection, word salad*. These terms are used for varying degrees of incoherence in which succeeding ideas seem to have lost all associated continuity.

6. *Vagueness*. A condition in which the goal idea seems uncertain

or is expressed so that it leaves the listener uncertain as to exactly what the patient does mean.

7. *Incoherence*. The successive parts of a sentence or sentences do not seem to hang together.

8. *Perseveration of speech*. This consists of the persistent repetition of a word or group of words in spite of the patient's attempt to change the topic.

9. *Blocking*. The sudden stopping of the stream of speech for which the patient is unable to account.

10. *Retardation*. This means that the thinking processes are slow and the thoughts are expressed with difficulty.

11. *Deprivation of thought*. This is an extreme degree of blocking. The stream of speech is arrested and there is no apparent thought content of any kind.

12. *Mutism*. The stream of speech stops and the patient will not speak in spite of questioning.

13. *Neologisms*. These are words which are of the patient's own making. They frequently consist of the condensation of several words or even sentences into a single word.

14. *Punning, rhyming, clang association*. These are also referred to as sound association and are frequently noted in flight of ideas. The patient uses words which sound the same but have a different meaning; e.g., whine suggests wine.

CONTENT OF THOUGHT

Disturbances of thought content take many forms and are at times difficult to elicit if the patient is suspicious and on his guard. Good rapport with the patient is necessary in most cases, although where the condition is well established, the disturbances of thought content are easily elicited and may be volunteered by the patient. The following symptoms should be particularly looked for:

1. *Fantasy*. Daydreaming is a matter of everyday experience and within certain limits may be considered normal. It is common in children. Fantasy becomes abnormal when the patient prefers to live in this dream world rather than to face reality. It is distinctly abnormal to derive pleasure from fantasy when the possibility of fulfillment is present. (See Mental Mechanisms.)

2. *Phobias*. These are unreasonable fears which the patient recognizes as illogical but which, nevertheless, persist and govern his actions.

3. *Illusions*. These are misinterpreted sensations which do, however,

have some foundation in fact. For example, a patient sees a dog and thinks it is a lion.

4. *Hallucinations*. These are sensations without an object. If the patient sees a nonexistent dog, that is an hallucination. As a general rule, it may be said that hallucinations are evidence of a psychosis. However, according to Henderson, they may occur in otherwise normal people. Their presence is of considerable importance in the evaluation of the patient because the "voices" may cause him to make a sudden, unprovoked attack on bystanders. Very frequently, although the patient may deny hallucinations, their presence may be deduced from the attitude of the patient, who appears to be listening or answering the "voices." Hallucinations may appear in the field of any of the senses. As a rule, they are divided as follows:

a) Pseudohallucinations, which the patient recognizes as the product of his imagination.

b) Hypnagogic, which occur in the interval between waking and sleeping.

c) Auditory, which usually occur in the form of voices but may also occur as bells or buzzing sounds. The voices may be friendly, hostile, accusing, male, female, etc.

d) Visual, which range from flashes of light or color to the terrifying zoological hallucinations of delirium tremens.

e) Touch or haptic, which the patient frequently describes as "like electricity touching me."

f) Lilliputian or microptic, in which the figures seen are much reduced in size.

5. *Delusions*. These are false judgments. It is apparent that all false judgments are not delusions. The definition should be qualified by the following statements:

a) That the subject matter be not true to fact;

b) That it cannot be corrected by an appeal to the reason of the person entertaining it; and

c) That it is out of harmony with the individual's education.

Delusions are usually subdivided as follows:

a) *Systematized or fixed* which, if the premises be granted, are logical and closely interrelated.

b) *Unsystematized*, in which the relations between the premises are poorly connected and not fixed.

c) *Grandiose*, in which the patient feels that he possesses unusual power or great possessions.

d) *Depressive*, in which the patient expresses extreme mental misery over acts which he is supposed to have performed.

e) *Self-accusatory*, in which are expressed ideas of self-belittlement and shame.

f) *Hypochondriacal and somatic*, in which the patient expresses a firm conviction that he has a physical disease in the absence of clinical evidence. This may progress so that he may express gross somatic delusions in which he feels that he has no stomach, that his brain is decaying, or that he has no "insides."

g) *Delusions of unreality*, in which things seem different and strange. *Depersonalization* is a state in which the patient loses his own sense of reality or the reality of others.

h) *Nihilistic*, in which he may deny the existence of himself or even of the world.

i) *Ideas of reference*, delusions in which the patient feels that chance incidents and casual remarks refer to him. In general, he feels that the remarks are uncomplimentary and derogatory in nature.

j) *Ideas of passivity*, in which the patient feels that his extremities are moved without his consent by an invisible agency.

k) *Ideas of influence*, in which the patient feels that his thoughts are being read or that he is under the control of another individual, e.g., electricity is being sent through the body.

l) *Ideas of familiarity*, in which the patient believes that the individuals or places which he now sees, he has seen before, but does not know when or where. This phenomenon occurs in some normal individuals.

m) *Ideas of unfamiliarity*. This is the opposite of the *déjà vu* phenomenon (ideas of familiarity), and the patient feels that places, persons, or things have changed from their old familiar appearances into something different.

Record in detail the patient's statements of beliefs that seem queer, and the meaning he finds for himself in these beliefs. Record statements about any strange sensory experiences, visions, or communications by unnatural means, and conviction of reality thereof. Note patient's reactions to any expression of doubt by examiner or others. "How did your family or friends take it when you told them about this?" Delusions should be scrutinized for indications of certain trends, such as:

a) *Persecutory trend*: Does patient say he is being watched? talked

about? wronged? robbed? poisoned? influenced by machines? electricity? mind reading? hypnotism? by other means? Does he express hostility or anger himself, or does he attribute hostility or anger to others? Does he appear suspicious? Has he been duped before? With good evidence? Are people against him?

b) Ecstatic trend: Does patient appear foolishly complacent, blissful, or untroubled?

c) Self-assertive trend: Whether or not patient shows delusions about himself, does he insist on independence? impose his wishes on others? demand service?

d) Self-depreciatory or self-accusatory trend: Does he blame himself for his troubles? Does he blame himself in a manner or degree out of reasonable relation to the evidence that he offers? If so, try to learn by whose criteria of blame he accuses himself so unreasonably. "Who suffers most by reason of your sins?" Does he cling or cringe? difficulty of decision? of thought? fear to be wrong?

e) Hypochondriacal trend: Has he considered himself in good health now and in the past? Nature of complaint. How has complaint interfered with duties and pleasures? Has he absurd ideas about his body? somatic delusions? (Be alert for metaphorical meanings, e.g., "no guts," "I'm dead," etc.)

6. *Obsessions.* These are ideas which dominate the mind and personality of the patient and which, although recognized as unreasonable, cannot be displaced from consciousness.

7. *Ambivalence.* This consists of the presence in consciousness of two contradictory ideas, both of which cannot be true.

8. *Preoccupation.* The patient ruminates on one topic to the exclusion of other interests and necessary activities.

9. *Autochthonous ideas.* Thoughts which come to the patient in some unaccountable way are strange, but are not dependent on hallucinations.

AFFECTIVE OR EMOTIONAL REACTION, MOOD, COMPLEXES

Affect may be defined as the individual's intellectual and emotional reaction to the influences of the environment. By affect we mean the individual's emotional response to an object or situation. Affect is the emotional response to objects, persons, places, environmental conditions, and, in fact, everything which may influence the individual. Affect includes object and feeling relationships.

Mood or Affective or Emotional Reaction

The emotional accompaniment of the patient's expressions is often of greater significance than the word itself. Affect, as used in psychiatry, means *the emotional tone in its relation to the thought content at any particular time*. In consideration of the affect, special attention should be given to its degree of fixation and appropriateness. The following terms are often used in the describing of affect:

1. *Euphoria*. This consists of a generalized feeling of well-being for which the patient has no adequate explanation.

2. *Elation*. Sustained euphoria.

3. *Exhilaration*. In this state an element of grandeur and pomposity has been added to elation.

4. *Ecstasy*. In ecstasy the expression of happiness is less robust than in elation and has, in addition, a celestial bearing and coloring.

5. *Sadness*. This becomes pathological when it is not warranted by circumstances.

6. *Anxiety*. In which the fear of danger comes from within the patient.

7. *Apprehension*. This differs from anxiety in that the source of danger arises outside of the individual.

8. *Apathy*. This refers to absence of affect and should not be confused with flatness or dulling of affect in which there is merely a decreased affect. Apathy is indifference to what ordinarily moves the feelings or excites interest.

9. *Instability*. This refers to impatient and angry responses elicited without stimulus.

10. *Morbid anger*. Unprovoked angry outbursts. Temper tantrums should be considered in this category.

11. *Emotional instability*. This term is used to indicate undue fluctuation of affect without external cause.

12. *Emotional deterioration*. This refers to progressive failure to show emotional response.

13. *Emotional harmony or disharmony*. Emotional harmony or disharmony signifies the presence or lack of appropriateness between thoughts expressed or behavior exhibited and mood observed.

14. *Ambivalence*. Ambivalence means showing opposite emotional attitudes toward the same object. For example, love, hate; joy, sorrow; elation, depression; happy, sad; desire, fear; forgiving, resentful; apathy, interest.

Summary of Affective States

1. *Harmony*: Is mood or emotional state in harmony with and appropriate to the expressed thought content?
2. *Elated*: Unduly happy, cheerful, optimistic, boastful, grandiose.
3. *Depressed*: Sad, dejected, humble, pessimistic, melancholy.
4. *Mixed states*: Apathetic, phlegmatic, unemotional, indifferent, angry, hateful, revengeful, irritable, distrustful, suspicious, fearful, anxious, perplexed, apprehensive, embarrassed. Emotionally unstable. Uncontrolled mood swings.

GENERAL KNOWLEDGE

Investigation of the general information possessed by the patient is a rough measure of his general intelligence and memory.

General Knowledge

This may be tested by such questions as the following:

- Who is President?
- Who was President before him?
- Who was President during the World War?
- Who is the governor of the state?
- Who is mayor of the city?
- When was the World War?
- When was the Civil War?
- Name the Great Lakes.
- Knowledge of current world events.

Reading, Understanding, Recall

The patient is asked to read any composition suited to his education. The *cowboy story* provides a standard method of evaluating ability to read. When he is finished, he is asked to repeat it from memory. Does he repeat it correctly and show evidence of understanding it? Does he read easily?

The cowboy story: "A cowboy from Arizona went to San Francisco with his dog which he left at a friend's while he purchased a new suit of clothes. Dressed in the new suit he went back to the dog, whistled to him, called him by name, and patted him. But the dog would have nothing to do with him in his new hat and coat but gave a mournful howl. Coaxing had no effect, so the cowboy went away and donned his old garments, whereupon the dog immediately showed his wild joy on seeing his master as he thought he ought to be."

Writing

Get a sample of the patient's handwriting on a separate sheet of paper. Note tremors, flourishes, elisions, cramped or bold style.

The patient is asked to write his name, to write a short sentence from dictation, and to write a short sentence of his own production.

General and School Knowledge

Questions of a general nature to reveal the state of general knowledge should include examination of current events to show the patient's recent attention. Questions of gradually increasing complexity will quickly reveal the state of the patient's school knowledge. Such questions as the difference between a king and a president, between water and vapor, a lie and a mistake, and ice and snow will gradually demonstrate the power of discrimination developed by the individual. Various other questions will indicate what the school knowledge is.

CALCULATION ABILITY

Have the patient count from one to twenty and then backward from twenty to one. Can the patient perform the simple operations of arithmetic, such as division, multiplication, addition, and subtraction? Can the patient do series of seven from one hundred or nine from one hundred? How accurately does he do this? How long does it take? Is it difficult or easy? Can the patient do simple problems involving percentages or fractions?

Calculation: Simple problems, such as the following:

$$100 - 7 = ?$$

$$6 \times 8 = ?$$

$$50 \times 3 = ?$$

$$93 - 7 = ?$$

$$7 \times 6 = ?$$

$$50 \times 12 = ?$$

$$86 - 7 = ?$$

$$5 \times 5 = ?$$

Knowledge of changing money.

JUDGMENT

Judgment is the operation of the mind involving comparison and discrimination, by which values and relations of things are formulated. It may be tested:

1. By suggesting to the patient a situation with two or more possibilities for his opinion or decision.
2. By the ability of the patient to discriminate between and to compare ideas.
3. By his management of life situations.
4. By his plans for the future.

Judgment is of two types, speculative and practical. Practical judgment is also called conscience. Conscience is defined as the practical intellect indicating that something is good and therefore to be performed, or evil and to be avoided.

Judgment: What are the patient's responses to problem situations? Does he seem to apply the criteria of reason to a situation before expressing an opinion on it? The patient's responses to problem situations should be recorded. For example, he might be asked, "What would you do if you were in a small boat far away from shore and the boat suddenly caught fire?" Or, "What would you do if you saw a person trying to break into a house on a lonely street late at night?" Or, "Do you think a man could jump from the fortieth story of the Empire State Building and then get up and walk away?"

The examiner should try to appraise the patient's intellectual resources and then give an impression as to whether he is utilizing them or not. Is his behavior and thinking "reasonable" or "unreasonable," and, if the latter, to what extent is it evidence of poor judgment or the lack of application of critical faculties?

INSIGHT

Insight may be tested:

1. By determining the patient's view of his own predicament.
2. By the extent of his realization of the nature of his illness.
3. By his acceptance of the fact of mental illness.

Does the patient realize he is ill? Does he think that he needs treatment? Does he evaluate correctly his faults and his successes? Degree of self-understanding. His future plans. What does he expect from the hospital?

ETHICAL QUESTIONS

An effort should be made to see if the patient distinguishes between right and wrong, moral and immoral, good and bad. Ask the patient what he would do if he found a lost purse on the road; how he would advise a man who had urges toward stealing, drinking, or immorality. Ask if lying is ever permitted. Is murder of the innocent justified?

INTELLIGENCE TESTS

Intelligence is an important factor in an individual's adjustment problems. For this reason, psychologists lay so much stress on the construction of tests for measuring mental abilities. Great impetus in this direction was given during World War I when the need for

proper classification and placement of military personnel was so strong.

Group and individual tests, containing verbal as well as nonverbal material, were developed to handle literates as well as illiterates or those with language handicaps. For purposes of greater economy of time and labor, group tests are used to examine a number of persons at the same time and by one examiner. The following are a few examples of group tests commonly used today in psychological clinics, schools, and industries: Otis Self-Administering Test of Mental Ability; Revised Beta Examination; Modified Alpha Examination — Form 9; Chicago Non-Verbal Examination; Heumon-Nelson Tests of Mental Ability.

Individual tests, as the name suggests, are given to one individual at a time. Because these are rather time consuming, they are usually administered to individuals who do not function adequately in a group situation or because of some mental or emotional disturbance may require the examiner to establish closer rapport and take note of any behavioral peculiarities of the subject. Some individual tests of intelligence in common use are: Revised Stanford-Binet Scale; Arthur Point Scale of Performance Tests, Revised Form 11; *Wechsler-Bellevue Intelligence Scale*.

The *Wechsler-Bellevue Intelligence Scale* is considered by most psychologists as the best available measure of adult intelligence. It consists of ten subtests and one alternate subtest. Five subtests are verbal and five are nonverbal or of the performance type. An interesting feature of this scale is that it makes it possible to compute both a verbal I.Q. and a performance I.Q. as well as an I.Q. for the full scale. Sample questions from the test are as follows:

- | | |
|-------------|--|
| Verbal | 1. General information: What does rubber come from?
What is the capital of Italy? |
| | 2. General comprehension: What is the thing to do if you find an envelope in the street that is sealed, addressed, and has a new stamp? Why should people pay taxes? |
| Performance | 1. Picture completion: Naming important missing part of picture. |
| | 2. Picture arrangement: Arrange in right order sets of pictures mixed up by the examiner. |
| | 3. Object assembly: Putting together correctly parts of a manikin, hand and profile. |

PROJECTION TESTS

Only one projection test will be described. This test usually called the Rorschach is the best known and most useful of these tests.

The Rorschach Method of Personality Study

Justin Koerner (1807) made the first recorded "ink blots" which were used for psychological testing, but the first real clinical evaluation was published by Herman Rorschach in 1921. His brilliant career was terminated in 1922 when he died at the early age of 37 only one year after the publication of his first description of the Rorschach Method in *Psychodiagnostic*. Many subsequent workers have contributed to the improvement and growth of the method.

It should be thoroughly understood that, valuable as the Rorschach Method is in personality study, it is nevertheless merely one tool in the armamentarium of the psychiatrist and not the complete answer to diagnostic difficulties. The projective method of Rorschach frequently induces the patient to reveal thoughts and emotions, which he might otherwise conceal, by telling what he perceives in the cards. This objective method enables the psychologist to understand the meaning and feeling which the patient's projections reveal. Thorough preparation is more necessary for the administration of the Rorschach test than for any other method of psychological testing, but it should be emphasized that it is actually a simple test to administer. Besides the ability of the examiner there are other factors which should be available for proper Rorschach interpretation. Among them may be mentioned: (1) the age of the patient, (2) his mood, (3) his physical condition at the time of the examination, (4) his visual acuity, (5) his social background, (6) his cultural and educational level. Color blindness, formerly considered important, has been shown by further investigation to be of little or of no consequence.

For the purpose of the test the ink blots are reproduced on cards 7 by 9½ inches and numbered from 1 to 10. These cards are handed to the subject one at a time and he is then asked to describe what he sees thereon. It is the object of the examiner to get as much projective personality material as possible from the subject and by leaving the patient severely alone during the test to avoid any distortion of this material by influencing the subject during the administration. As much time as is necessary is allowed for the subject to view the card and express his findings. Everything he sees in the blot is recorded

with the time interval and the position of the card. Each response is scored as to the following:

1. Whole response (W), i.e., taking the whole blot and forming an impression.
2. Whether or not the white spaces (S) are used.
3. Whether or not a large segment of the blot is used to give a response (D).
4. Responses based on small details of the blot (Dd).
5. The content of the forms.
6. The originality or popularity of the response (O or P).
7. Movement (M: human movement; FM: animal movement).
8. Shading, as diffusion and color (C), both with and without form (FC and CF).
9. Total number of responses.
10. The reaction to the color cards is noted to determine whether or not there is present what is called "color shock," a reaction most frequently seen in patients suffering from a severe neurosis. "Shading shock" more recently described has the same significance.

Proper interpretation of the above items reveals much of the general personality structure of the subject. It reveals the extent of introversion or extroversion and the mode of controlling these forces. An attempted overcontrol of these reactions will give a constriction of the subject's reactions. Insecurity and anxiety are demonstrated. The intellectual aspect of the personality may also be determined by the number and quality of original, whole, and movement responses. The subject's color responses give best evaluation of the emotional aspects of the personality. In the severe neurotic delayed reaction time to color cards, paucity in the total number of responses, and rejection of color in determining the forms of responses are characteristic.

More specifically the characteristic responses for the more important clinical conditions may be briefly outlined as follows:

1. *Intracranial organic pathology.*
 - a) Low total number of responses.
 - b) Most of the responses are whole responses without clear, adequate forms.
 - c) The time interval is prolonged.
 - d) Color naming.
 - e) Perseveration of response to several ink blots.
 - f) Recognition of inadequacy of response but an inability to do anything about it.

- g) Perplexity, a distrust of ability and a request for reassurance.
- h) Automatic phrases, use of a phrase in an indescribable fashion, e.g., "That's all I can say."

2. *Schizophrenia*. Due to the great variety of clinical pictures in schizophrenia there is no characteristic Rorschach picture. The following are typical responses:

- a) Manner of approach to the test.
- b) Increase in the number of whole responses but a decrease in their quality.
- c) Paucity of movement responses except in paranoid type who may show many human movement responses.
- d) Increase in number of color responses.
- e) Definite decrease in good form and popular responses.
- f) Occasional blocking and refusal to give responses to certain cards.
- g) Originals usually poor but good and poor originals may occur in same record.
- h) Poverty of ideas may be demonstrated, a typical schizophrenic response being to describe the cards merely as ink blots, lines, or designs.
- i) Marked variability in the form accuracy.
- j) Responses based on the position of the area used in relation to the total blot.

3. *Psychoneuroses*.

- a) Color shock or color shading is the most important single sign.
- b) Total number of responses is seldom over 25.
- c) Harrower-Erickson's signs:
 - 1) Number of responses not more than 25.
 - 2) Number of human movements not more than 1.
 - 3) Animal movement greater than human movement.
 - 4) Color shock.
 - 5) Shading shock.
 - 6) Refusal to respond to one or more cards.
 - 7) Percentage of form responses greater than 50.
 - 8) Animal percentage greater than 50.
 - 9) Form-color responses not more than 1.

Normals show 0-3 signs. Neurotics show 3-9 signs.

The Rorschach pattern is less helpful in substantiating a diagnosis of (1) the convulsive disorders, (2) the depressive states, (3) mental deficiency, and (4) juvenile delinquency. The Rorschach is an important index of the patient's progress.

SUMMARY

The mental examination is the equivalent of the physical examination done by the general physician. It should be complete. Do not be satisfied with a discussion of the presenting symptoms. Explore all areas of the personality. Incomplete examinations are evidence of mediocre work. A thorough examination of the patient under your care is a serious obligation.

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PART IV

THE PSYCHONEUROSES

CHAPTER

- XVI. THE GENERAL APPROACH TO THE PSYCHONEUROSES
- XVII. THE INDIVIDUAL PSYCHONEUROSES
- XVIII. GENERAL PRINCIPLES OF TREATMENT

THE GENERAL APPROACH TO THE PSYCHONEUROSES

It has been previously pointed out that man is possessed of a body and a soul, with external senses, internal senses, an intellect, and a free will. Through study and observation, it becomes increasingly more evident to us that no two individuals are alike, in either physical or psychic make-up. One observes, on the contrary, that marked individual differences prevail throughout the human race. Varying degrees of mental and physical potentialities and actualities are everywhere present. Constantly, the tangible results of environment, training, and personal effort are evident.

In the development of the individual and in his consequent deviation from others, two important psychic entities, habit patterns and goal formation, play a significant role. Habit patterns, often the result of youthful identifications, displacements, and processes of conditioning, soon become second nature to each person. Similarly, each individual early becomes aware of certain goals, which later on, as a fully developed matured person, he should normally attain. These goals, moreover, being in keeping with man's social nature, prompt the individual to seek such ends as will enable him to function smoothly in the society of others. He wishes to be accepted, appreciated, sought, and welcomed by his fellow men. The individual envisions himself as socially established, domestically successful, and economically secure. He desires to feel reassured by the inner voice of conscience that he is doing his duty and playing his part manfully in making the world a better and more secure abode for himself and others.

Man is guided not only by intellectual goals, however. He is also affected by less tangible influences, such as instincts, feelings, impulses, and emotions. These forces, being frequently at war with each other, make of man's psychic life a battleground upon which numerous contending forces strive for mastery. The very atmosphere in which contemporary man lives aids in the formation of problems and conflicts. Thus, frustration, as well as success, becomes a component of everyday living.

To be able to maintain composure and reach his goals in the face of these difficulties, man must be able to meet his conflicts with at least substantial success. A self-disciplined character, a purpose in life, an appreciation of the value of deferred pleasures, and a well-established set of principles are necessary to the maintenance of mental and emotional equilibrium. In this respect, the normal man differs markedly from the neurotic individual. The former, though not free from feeling, emotion, and conflict, has learned to cope with his problems and resolve his conflicts more effectively than has the latter, who, with defective habit patterns and faulty goal realization, is unable to make an adequate adjustment to the ordinary demands of living.

DEFINITION OF THE NEUROSES BY VARIOUS AUTHORS

The concept of the neuroses as held at the present time is the product of a long process of psychiatric thought, in which the classification of the neuroses has undergone a gradual but marked change. This becomes evident through a glance at the Table of Contents of older medical and psychiatric textbooks, wherein it is noticed that many disorders which today are recognized as organic diseases were classified then as neuroses. "Practically all older authors placed hysteria and neurasthenia under the neuroses. Under that same caption other authors included impelling fears, obsessive compulsive ideas, astasia-abasia, traumatic neuroses, hemicrania, headache, vertigo, epilepsy, eclampsia, chorea minor, Huntington's Disease, paralysis agitans, and numerous other diseases."¹ The same idea is expressed by more modern authors:

More recently as the causes have been ascertained, more and more of the "neuroses" have been chalked off the list. For instance, only a few decades ago tabes dorsalis passed as a neurosis. It is still more recent that tetanus and hydrophobia were counted among the neuroses. Acromegaly, Basedow's disease, tetany, and so on, had to be removed from the neurosis group when they were demonstrated to be endocrine diseases.²

In order to clarify our concept of the word "neurosis," it would be well to consider definitions of the term as given by various authorities at different stages in the development of psychiatric thought, and then, from these definitions to draw conclusions and generalizations concerning the nature of this particular type of mental illness. A gradual change in emphasis from the physical to the psychical will be noticed in the following definitions:

1. The term "neurosis" comes from the Greek word *neuron*, which means "a nerve." Originally, the word "neurosis" signified an organic disease, a physical nervous disorder. For quite some time the term preserved this connotation of organic illness.

2. *Neurosis* was early defined as a "change in the nerve cells of the brain prior to and resulting in psychic activity."³ From this it can be seen that ideas concerning organic etiology of the neuroses were early in evidence.

3. A later tendency arose to employ the word "neurosis" for those moderate personality deviations from normalcy which seemed to be *organically caused*, and the term "psychoneurosis" for similar mental disorders whose cause was thought to be of psychogenic origin.

Until comparatively recently, the term "neurosis" was reserved for those disorders in which the cause of the various mental and physical symptoms were supposed to contain more or less vaguely defined physical factors, while the term "psychoneurosis" was applied to those disorders in which these symptoms were attributed to mental forces.⁴

4. Noyes remarks: "The word neurosis as now used may be said to refer to a functional disturbance of the nervous system, which, if directly due to etiological mental factors, is spoken of as a psychoneurosis."⁵

5. The *Oxford English Dictionary* emphasizes the psychic etiology of the neurotic disorders by defining a psychoneurosis as "a mental disorder especially without any organic lesion or recognized mental weakness."⁶

6. Similarly, the *American Illustrated Medical Dictionary* defines neurosis as "a nervous disease: more especially a functional disorder of the nervous system."⁷

7. Bing and Haymaker define neuroses as including only "those nervous disorders not dependent upon any change in the nerve cells but which occur rather on the basis of a functional disorder."⁸

8. Henderson and Gillespie give a descriptive definition of the neuroses as follows:

A psychoneurosis implies either a bodily disturbance without structural lesion, and dependent in a way unknown to the patient on mental causes; or a mental disturbance, not the result of bodily disease, in the form usually of morbid fears, or more rarely of persistent ideas or motor acts, all of which the patient realizes to be abnormal and the meaning of which he is at loss to understand. The bodily disturbances

may be sensory and entirely subjective, or motor and, therefore, directly observable, or visceral.⁹

9. The authors of "Outline of Neuropsychiatry in Aviation Medicine" define neuroses as:

A group of disorders in which mental forces or ideas, of which the subject is either conscious or unconscious, serve to bring about various mental and physical symptoms.¹⁰

10. Ross considers the neuroses as "a congeries of symptoms which are of the nature of a crystallization of the emotional reaction."¹¹ In another of his books, Ross states that a neurosis is "a functional or psychogenic disorder where no physical lesion has been found . . . a faulty adaptation to the stress and strife of life."¹²

11. The psychogenic element in the neuroses is emphasized in the following definition of Chadwick:

Neurosis is a form of nervous disorder, and the symptoms are the result of a conflict between warring elements of infantile impulses, the ego, and the environment, because of the action of repression.¹³

12. Brown gives this definition:

By psychoneurosis we mean the milder abnormalities of the cognitive, emotional, and motor processes, which usually only partially incapacitate the individual and where the basic symptoms are somehow connected with anxiety. Psychoneurotics are individuals who because of their conscious or unconscious conflicts are prevented from arriving at the accomplishments of a productive sort which would normally be expected of them in consideration of their abilities and culture.¹⁴

In light of the foregoing explanations and definitions of the neuroses the following conclusions are, we think, justified:

1. Neuroses are *defensive mechanisms* which are utilized to preserve the individual from the result of deflating experiences that threaten his ego.

2. They are a group of *personality reaction patterns produced by warped habits* which had their origin in insecurity, fear, and worry.

3. Neuroses are *disorders of psychogenic origin* characterized by more or less habitual personality deficiencies and erroneous attitudes toward life caused by unsolved conflicts, early frustration, and an urge to escape depressing emotions.

4. They are disorders in which *psychic forces beget various mental and physical symptoms* which serve as a means of escape and protection from irritating emotions.

5. Neurotic symptoms *symbolize* unsatisfactory patterns of adjustment to conflicts that threaten the personality.

6. Neuroses are syndromes which represent a balance or *type of equilibrium* reached by the individual between his own psychic forces and the disintegrating influences of his environment.

7. The neuroses are psychic disorders in which disabling *symptoms* arise *consequent to the deep and profound realization that life's conflicts have not been adequately solved.*

The first use of the term "psychoneurosis" is credited to Paul Dubois.¹⁵ Bernheim (1840-1919) also used the term for hysteria and allied conditions. *In harmony with modern practice we use the words "neurosis" and "psychoneurosis" as synonyms.*

NEUROSES NOT IMAGINARY

On completing the physical examination of the patient and finding all the organs in good condition, one might be inclined to look upon the neurotic as an individual for whom life has proved too strenuous, and judge his symptoms merely as the product of a vivid imagination. This, however, would be an erroneous conclusion, for the patient actually does have the symptoms of which he complains. To consider these manifestations imaginary, therefore, is not only incorrect, but also unjust. The neurotic does suffer keenly, and though his ills and pains have a psychic or emotional origin, they are nevertheless as irritating and distressing as though they were caused by external stimuli or internal disease.

Ross says: "An imaginary pain is a contradiction in terms. If I say I have a pain, I either have it or I am a liar. There is no possibility of my having a pain which is not present."¹⁶

Henderson and Gillespie elaborate on this idea by stating that:

. . . these disturbances are emphatically real and not "imaginary." An hysterical pain is a real pain. The motor signs are paralysis, paresis, tics, tremors, postural deformities, anomalies of gait, and speech (not language) disorders such as aphonia. The visceral disturbances include tachycardia, vomiting, diarrhea, constipation, sialorrhea, polyuria, sweating, and vasomotor disturbances generally. The mental disturbances appear as fears of all kinds, e.g., of heights, of sounds, of open spaces, and especially of bodily illness; as localized losses of memory (islands of amnesia); as trance-states and somnambulism; as troublesome thoughts, usually with an uncomfortable feeling attached to them as anxiety; or as acts which the patient feels compelled to do.¹⁷

Nor must we think of the neurotic as consciously and voluntarily assuming symptoms in order better to evade responsibility and escape blame for goals not realized and duties not accomplished. Neurotics usually think quite obscurely and the major issues of their conflicts are not always clear to them. Hence, they have difficulty in segregating the essentials from the accidentals of a problem.

NEUROTICS ARE EMOTIONALLY DISTURBED

In general, when discussing the intellectual and voluntary activities of neurotic individuals it may be well to remember that we are dealing with people who are mentally ill. Much of what constitutes their psychic life is not clear to them, for they have no definite knowledge of the goals and motives that influence their activities. These dynamic elements are often vague and may exist at best only in marginal consciousness.

NEUROSIS MAY BEGET ORGANIC DISEASE

The implication that neuroses are unaccompanied by physical changes must be correctly understood. Psychic activity usually implies physiological change of some type. This activity takes place not in a vacuum but in a living being vibrant with action. Consequently, there is usually a physical change whenever there is psychic activity. In the case of the neuroses, however, such physical changes are physiological.

Although the neuroses are of themselves psychogenic in origin, it is possible for them to give rise to physical changes which, if persistent, will result in the development of organic disease. This condition may come about in several ways, but it most frequently results from the overactivity of the sympathetic nervous system which is so often affected in neurotic disorders. Examples of such a disturbance may be clearly seen in cases of essential hypertension. In the early stages of this condition the elevation of the blood pressure usually results from a vasospasm due to anxiety or poorly repressed hostility. At first the vasoconstriction is short-lived and the blood pressure fluctuates widely but with continuance of the anxiety or of the repressed hostility the vasoconstriction becomes more persistent and finally results in arteriolar sclerosis. This is the organic basis of essential hypertension. Similarly, a mechanism of suppressed aggression may produce such organic conditions as peptic ulcer and ulcerative colitis.

Another relationship between the neuroses and organic disease is seen in the so-called "compensation neuroses." In this condition, an injury, usually of minor consequence, occasions an exaggerated display of neurotic symptoms. Almost always associated with such cases is a very obvious element of personal gain.

ETIOLOGY OF THE NEUROSES

In discussing the etiology of the neuroses, all psychiatrists, irrespective of their particular schools of thought, seem to maintain the following four pivotal points in common:

1. *The earliest days, weeks, months, and years (1-6) of the child's life are those in which the neuroses have their origin.*

2. *The pathological psychic habits of children are usually the result of anxious attempts to defend the ego against the inroads of insecurity and deflation, and such habits usually trace their origin to frustration, fear, worry, anxiety, unsolved conflicts, and emotionally traumatic experiences.*

3. *Adult neurotic symptoms take their tone, color, texture, and type from the early neurotic picture developed by the child.* A profound conviction exists among psychiatrists that the earliest days, weeks, months, and years (1-6) of the child's life are those in which mental disorders have their origin. It is an almost universally accepted tenet that in the child's preschool days (1-6 years) ample opportunity is afforded to develop a permanent point of view or what might be termed a philosophy of life. This philosophy of life developed by the child may be based more on emotional reaction to success and failure than on reason. Many authors call attention to the fact that children while still quite young are able to grasp effectively the nature of defeat and frustration and display the psychic and physical symptoms connected with them. All psychiatrists, moreover, admit the early appearance of some type of knowledge in children and their awareness of unsolved conflict. There is, therefore, enough psychic life in the years one to six to constitute a basis for the development of a neurosis, for emotions and feelings may mean more to the child and growing youth, and may exercise greater influence on habit formation than do abstract principles. Only too often, unfortunately, is this also true in the lives of adults, for the significance of deferred pleasures does not immediately dawn on individuals, but requires prolonged and careful training.

For the child's physical development and perfection a due propor-

tion of food, air, rest, sunshine, and exercise is demanded. For his psychic development and perfection it is also necessary that the child from his earliest moments experience an atmosphere of love, security, sympathy, and understanding. He must be able to forget his own childish weakness and identify himself with the strength, success, calm, and peace of his parents. Parents and teachers should, therefore, so organize the environment that the child may be able, without undue effort, to realize relative fullness of life and development of personality through properly understood self-expression. Difficult to find though it is, an ideal environment for the development of the child should not be too harsh, on the one hand, nor too sheltered on the other. It is imperative so to develop the child that he will be prepared to meet adult conflicts without regression.

Since the adult neurotic is the child of the past, it may be observed that adult neuroses reflect the neurotic patterns of childhood. The beginnings of adult neuroses can most frequently be connected genetically with the warped development of early years. There is nothing surprising in this, for life is continuous, and the awkward, inefficient modes of thought and psychic habits of childhood do not automatically take on a superior tone with the passage of years or even with the advent of adulthood. Such patterns of conduct have, on the contrary, a habitual tendency to repeat themselves. They even become second nature to the child and, unless corrected, will persist into the mature adult years of the individual.

4. *Adult neuroses are built on the vague recollection of childhood traumatic experiences:* The frustration, points of view, and depressing emotions derived from the faulty solution of childhood conflicts, continuing as memories and displacements, into the child's developing years and taking on varying shapes and forms, ultimately appear as the full-blown adult neurotic syndrome.

This is inevitable, since the human being, who cannot resolve the conflicts with which he is confronted in life, invariably develops manifestations of anger, depression, frustration, and anxiety. The unsatisfactory solution of a conflict begets in the individual a sense of inner personal insecurity, a feeling of ego deflation, and a realization of self-created inability to make good. Thus, deflation enters into the individual's psychic life and further progressive efforts seem to be paralyzed. The awareness or consciousness of unsolved conflicts develops new inner tension and adds to the difficulty of social relationships. New fears spring up concerning the possibility of future inability

to meet life's issues. Depression, fear, and deflation are present in the life of the adult and these are the shadow or continuation of childish emotional traumata. In general, the foregoing represents the common doctrine of psychology and psychiatry concerning the etiology of the neuroses:

It is not incorrect, therefore, to say that the adult neurotic patient is basically afraid of the danger situations of his childhood.¹⁸

The adult outbreak is seldom the first stage of neurotic illness. The child is often suffering from a real frustration of infantile impulses, whereas the adult only remembers such frustrations and in phantasy dreads their recurrence.¹⁹

We find a similarity between neuroses that appear in children and adult neuroses, because the adult neuroses represent the neuroses of childhood. Again, one discovers in one's work with older children and with adults that they usually have had a previous period of neurosis or some neurotic tendency in early childhood.²⁰

In speaking of the adult neurotic, English and Pearson give the accepted psychiatric doctrine when they inform us:

He responds to external situations as if they were replicas of his infant situation.²¹

The adult neurotic was already neurotic in childhood.²²

The frustrations and disappointments productive of adult mental disorders have a similarity to corresponding ones of childhood.²³

Here, as elsewhere, it appears that the child is father of the man. The future neurotic is the child of the past. It is further evident that neurotic symptoms which appear in adult life take their form, tone, and texture from those of childhood.

Adult neurotics display well-defined symptom complexes. There is little doubt that although neurotics as a group preserve their mental powers unimpaired and are able to lead a somewhat normal life, their neuroses often lead them into behavior which seems anything but normal.

The neurotic is not feeble-minded, however. On the contrary, he usually has average or above-average intelligence. Even so, he does not enjoy life fully nor derive much pleasure from his work. He has no relish for enterprise and seems tired, static, fearful, or indecisive. Obsessions or compulsions frequently oppress him, and his physical

and mental powers do not always function smoothly. On the whole, therefore, the neurotic gives the impression of having found life too complicated, and its problems too numerous and harassing for satisfactory adjustment.

It may clarify our discussion on the development of adult neuroses if the following three factors are kept clearly in mind:

a) The neurotic has deep and depressing emotions and has them almost habitually.

b) The neurotic thinks feelingly and emotionally rather than intellectually or rationally.

c) The neurotic's conflicts, being largely in marginal consciousness, are usually not clear to him.

Much mental suffering surrounds the neurotic's every action. He becomes more keenly aware of his lack of success in life's pressing issues and his personal security seems threatened. To complicate matters still further, he feels that his present precarious condition is largely of his own creation. He is dissatisfied with the status quo and his ego suffers severe deflation. Phobias, apprehension, and a sense of inferiority becloud his psychic life. His fears are not so much of external objects as of internal unrest and turmoil. To reason coldly and objectively toward the solution of his problems, however, is usually beyond the powers of the neurotic, for the emotions have so upset his psychic life that the intellect is able only with difficulty to form the judgments, connections, and insights necessary for the resolution of the conflict.

The emotions have so upset the physical and psychic life of the neurotic that he is in no position to put forth his best efforts in objective reasoning. It is a well-known fact that the intellect depends for the clarity of its ideas on the antecedent clarity of the imagination to such an extent that the emotions profoundly inject themselves into the psychic processes and produce the various symptomatic constellations known as neuroses or psychoneuroses.

CLINICAL NATURE OF THE PSYCHONEUROSES

The following descriptions will serve as a classification of the major types of neuroses. It must be kept in mind, however, that the various forms of the psychoneuroses are not rigidly fixed, but rather tend to merge one into the other.

1. *Psychasthenia or obsessive-compulsive neuroses*: In this group of neuroses, the symptoms are primarily of the psychogenic type.

Fears, phobias, doubts, panic, indecision, fixed ideas, scrupulosity, obsessions, and compulsions characterize this type of mental disorder.

2. *Neurasthenia*: If the symptoms belong to the psychosomatic group, they display themselves in somatic complaints, marked insomnia, irritability, and intense physical or mental fatigue.

3. *Hysteria*: If the effect of the conflict be sufficiently intense to result in the loss or lowering of a function, the neurosis is known as hysteria or conversion hysteria. Hysteria leads to functional disorders, anesthesia, disorders of movement, and disturbances of the special senses.

4. *Hypochondriasis*: This type of neurosis exhibits a profound preoccupation with bodily organs and functions as well as with the general state of health.

5. *Anxiety neurosis*: Anxiety neurosis is a psychic disturbance which results in severe mental conflict, intense anxiety, fear, apathy, depression, sleeplessness, dreams, and tremor. It frequently is referred to as "neurosis of expectation" and as "anticipation neurosis."

6. *Reactive depression*: Reactive depression is an acute and usually transitory state of depression associated with fear, anxiety, and worry. The depression is the result of difficult and harassing situations.

There are few organic diseases which, in the early stages of their development, may not be mistaken for functional conditions. Unfortunately, the converse is also true, and a true psychoneurosis may be suggestive of an organic disease.

In this respect, it is well to remember that the neuroses "depend on the continuation of emotional disharmony (mental conflict) and disappear when harmony is restored. Organic disease may be present, but neurotic symptoms are never directly dependent on it; they may be indirectly, if the patient is anxious about his disease."²⁴

SYMPTOMS ARE IMPORTANT

Since *a symptom is a subjective manifestation of disease*, it is an indication of the conflict which produced it rather than the source of the conflict itself. Symptomatic manifestations are important in that they may lead us to a knowledge of inner mental conditions, but one should never concentrate on the symptoms of the illness to the exclusion of the search for their cause. The delusions of an inchoative schizophrenic, for example, are often the main object of concern of parents and relatives. "If only he could get over the feeling that he is being persecuted," they say. This reaction is only

natural, of course, for the delusional symptom is very impressive and most people are not schooled to realize its exact nature. The person who has some familiarity with psychiatric concepts, however, soon learns not to be distracted by symptoms in the all-important search for causes.

CASE 15: *Phobia in Which the Treatment of Superficial Symptoms Delayed Recovery*

A college student was deeply agitated by strange fears. He was a leader in class and on the campus; was a good athlete; and was called by his fellow students the "pope," because of his ability to answer difficult questions quickly and accurately. He was an excellent Catholic and conversant with the teachings of his religion. He took a light course one summer and spent most of the time working. His miserable scholastic performance attracted the attention of the instructor, who knew he was capable of better work. Upon inquiry, he found the boy most unhappy because of recently developed religious scruples. The instructor referred him to a priest, but sometime later discovered that he had not been helped. In desperation the boy related his story to the teacher: the conviction that it was a sin to smoke or spit. Not knowing what else to do and having never heard before of such a state of mind, the young instructor prescribed a series of remedies. He argued and proved convincingly to himself that it was not wrong to smoke or spit. He smoked and spat himself. These devices helped not at all. He signed a written statement that such was the case and begged the scrupulous youth to take it out and read it when he felt the need. The instructor spent the entire summer attempting to clear up the symptoms, with no success. It never dawned on him that a scrupulous mind or abnormal fear was at the bottom of it all. Fortunately, at the fall session, the youth found more competent help, and his condition was improved in a short time.

Symptoms, like messages written in a foreign language, need interpretation. It is easy to state the generic fact that symptoms are only indications of underlying pathology, but it is much more difficult to pronounce on their method of interpretation. No easy thumb rule can be given, for this important aspect of the psychiatrist's training is acquired only through study and experience. The following three factors complicate the task and should be clearly understood by all students and practitioners of psychiatry.

1. *Many symptoms are symbolic.* Ordinary signs, once compre-

hended, lead easily and directly to a knowledge of the object designated. Psychiatric symptoms are not so easily understood, however. Amnesia, delusions, and auditory hallucinations may be complex and bizarre symbols of fears, desires, or erotic urges of the patient. Hysterical vomiting may be a sign of deep disgust, while psychogenic paralysis or anesthetics often symbolize emotional stress. In the case of even the most arbitrary of signs, the symbolization employed is a secret which the patient understands but vaguely, and which the unconscious mind guards with jealous zeal. Skillful probing and painstaking analysis of the patient's status quo is required.

2. *Symptoms are specific.* A delusion of persecution may be an exterior sign of systematic projections of personal failure, or prolonged rationalization, of psychological self-defense, or almost any other mental disturbance. In order to interpret symptoms correctly, therefore, it is necessary to possess a complete picture of the disordered personality. This picture can be attained only after careful and repeated examination, and in its construction, the history of the patient's mental, emotional, and volitional life is of particular importance. Most symptoms, whatever their cause, are purposeful and habitual expressions of personality needs or desires. Familiarity with the individual's past will often bring to light the exact purposes which symptoms are supposed to accomplish.

3. *Symptoms are purposeful.* One of the important advances made by psychiatry has been the recognition of symptom purposefulness. To the inexperienced, symptoms often have no specific meaning. In a general way, of course, they have always indicated disorganization and mental collapse. But psychiatry has learned that symptoms have to the patient a much more specific meaning. And the interpretation of this meaning or teleology is the great concern of the psychiatrist. The pseudo-paralysis of the organs of an hysterical patient, for example, does not have the same meaning as the real paralysis of a person organically ill. Once the doctor is convinced of the correctness of his diagnosis, his big search revolves about the question, "What does this paralysis mean?" *The general purpose of the symptoms of mental disorder is to lead the patient away from painful reality.* This principle has become axiomatic in psychiatric practice. Some symptoms are more successful than others, some more deeply rooted in the personality. All things being equal, the more perfectly the symptom achieves its purpose, the more profound is the mental disorder. It is the intention of the psychiatrist to unearth

the specific purpose for which the symptom was created, and thus to reach the root of the difficulty. Although symptoms are purposeful, it is important to remember that no individual consciously assumes his disabling symptoms.

REFERENCES FROM AUTHORITIES

In order to bring out more clearly the teleology underlying symptom formation, we think it well to insert the opinions of several outstanding authorities on this subject.

1. *The desire to escape conflicts is probably the beginning of the development of a neurosis.* According to the *Technical Manual*:

The element of wish or will cannot be totally excluded from this formula, as there is a great deal of evidence at hand to suggest that in many cases the first conscious manifestation of a beginning neurosis is the desire that something might intervene as a protection from the conflicts arising out of a particular stress of circumstances. As long as the necessities of the occasion are taken into account, there is every reason to admit that desire, wish or will has a place in the preliminary state out of which a neurosis is finally developed. This wish or will to develop a neurosis is perfectly understandable if it is kept in mind that behind the wish is a deep-lying need, influencing the patient in that direction. In the development of a neurosis, behind the wish, expressed or unexpressed, on the part of the patient to be ill, there are the activities of a deeper lying instinctive appeal which has for its object the safeguarding of the total organism.²⁵

2. *The symptom is symbolic in the sense that it has meaning for the patient.* This meaning is eventually purposive, the symptom being a solution, however unsatisfactory, to some problem of everyday adaptation. Noyes says:

Broadly speaking the psychoneuroses are substitutive reactions in which the symptoms play some concealed but nevertheless useful role in the mental life of the patient. These symptoms serve their useful purpose without resulting in behavior that is regarded as particularly strange or abnormal. Although the patient's symptoms often appear to be but unpleasant inflictions yet in reality they serve also as disguised means of protection or satisfaction.²⁶

Strecker and Palmer remark that

The psyche of every human being is to some extent, at least, a battleground of conflicting trends, desires, and emotions. The majority of us, nevertheless, "carry on" satisfactorily enough by a series of

more or less adequate compromises. Let there occur, however, a flaw in the armor presented to the environment, perhaps by reason of a physical incapacity, then there are at hand both the opportunity and the psychological temptation to ease the conflict by employing the mechanism that converts emotional problems into physical symptoms.²⁷

And, they continue,

... with no solution available there is unconsciously found a refuge in the haven of a psychoneurosis.²⁸

Freud, too, observes that

... a solution of the conflict by a symptom-formation is the most convenient one, most in accordance with the pleasure-principle for it undoubtedly spares the ego a severe and painful piece of internal labor.²⁹

He further states that

... In the ordinary way it is apparent that by flight into neurosis the ego gains a certain internal "advantage through illness," as we call it; under certain conditions a tangible external advantage, more or less valuable in reality, may be combined with this. To take the commonest case of this kind: a woman who is brutally treated and mercilessly exploited by her husband fairly regularly takes refuge in a neurosis, if her disposition admits of it.³⁰

THE NEUROTIC DOES NOT ENJOY ALL ASPECTS OF HIS SYMPTOMS

It is evident that though the neurotic vaguely desires his symptoms, he does not appreciate the painful reactions and the inconveniences occasioned by them. No one really enjoys physical pain, exhaustion, or indigestion. And yet such reactions may be more tolerable than are the consequences which flow from being well. Hoarseness of voice, for example, is often more acceptable to the individual than is the hazard of giving a speech. Hoarseness, in such cases, offers a better protection to the ego than does the unrestrained power of speech. Thus, the unpleasant aspects of neurotic symptoms are often the lesser of two evils. As Freud puts it,

As a rule it is soon apparent that by accepting a neurosis the ego has made a bad bargain. It has paid too heavily for the solution of the conflict; the sufferings entailed by the symptoms are perhaps as bad as those of the conflict they replace, and they may quite probably be very much worse. The ego wishes to be rid of the pain of the symptoms, but not to give up its advantage through illness; and that is just what it cannot succeed in doing.³¹

AT MOST THE NEUROTIC HAS MARGINAL AWARENESS OF THE PROCESS UNDERLYING SYMPTOM FORMATION

Though symptoms have a certain value to the patient, much of the process of symptom formation and especially the connection between these symptoms and the conflict is not recognized by the neurotic. Often the very conflict itself in all its details is not clear to him. It is but marginally recognized.

It is a well-known psychological fact that the individual while under the influence of strong and depressing emotions, is unable to think correctly. In such instances a person frequently attends to his emotions, symptoms, and complexes rather than to the basic unsolved conflict which originally produced them. With the passage of time, he attends progressively less to the actual conflict and its cause and more to the symptoms which he now comes to regard as physically rather than psychically generated. Later on, because of increased emotions, he may so completely attend to the symptoms as totally to ignore their cause and in fact to be practically unaware of it. The actual cause of the symptoms, the unsolved conflict, remains, however, and it is this that has developed the anxiety in his life. The neurotic, at most, has but marginal awareness of this unsolved conflict. In neurotic symptom development the details of the entire picture are not kept in clear perspective. The symptoms are much more in evidence than is the conflict or the cause of the conflict. The conflict is often obscure due to the fact that, being unpleasant, it is marginally repressed. The whole story or history of the event is rarely formulated in clear fashion.

It can thus, we think, be said that neurotic symptoms are purposeful and yet the processes of repression, conditioning, and displacement make the patient quite unaware of the cause of the symptoms or at least render him oblivious of any definite connection between his conflict and his symptoms. The teleology of his symptoms evades him, and the source of his conflict remains a mystery to him.

DIAGNOSIS OF NEUROTIC CONDITIONS

There are definite characteristics which indicate the presence of psychogenic disorders. This is contrary to the belief of most practitioners that the diagnosis of the psychoneuroses is dependent upon the exclusion of organic disease. As has been pointed out, the mechanistic concept of disease has been so deeply rooted in the

teaching of the medical profession that many doctors exhaust themselves and frequently their patients as well, both physically and financially, in vain efforts to find a physical cause for the clinical picture. The net result of this procedure is usually a frustrated physician and a disgusted patient. Although the psychosomatic concept of disease is becoming more accepted, the average practitioner still feels somewhat insecure in his diagnosis of functional disorders.

In every instance, of course, the approach to the case should be by means of a careful personal history and physical examination. Physical disease may be present and still not be etiologically significant. There are, however, positive clinical features which of themselves point to a functional disturbance rather than to an organic disease. They also indicate to some extent whether organic disease be present or absent. *The positive clinical features characteristic of the neuroses may be summarized as follows:*

1. Defective control of emergency autonomic mechanisms which give rise to the physical changes characteristic of anxiety, guilt, and similar conditions.
2. Evidences of disturbance of the sympathetic nervous system.
3. Conversion symptoms.
4. The presence of abnormal ideation with insight, i.e., the presence of obsessions, compulsions, and various phobias.
5. The presence of an etiologically significant conflict, either in focal or marginal awareness, of high emotional value.
6. An element of gain.

Negative Features of a Neurosis

Among certain negative features characteristic of the neuroses, the most important is the absence of etiologically significant organic pathology as well as those changes which are more characteristic of a psychosis or physical disease. "To say it is a neurosis not only must organic elements be excluded, but there must also be evidence of a conflict that produced it."³²

Recognition of the Psychoneurotic Character

The quick recognition of the psychoneurotic character of a patient's symptoms may be of the utmost importance. No hard and fast rule can be laid down, however. Familiarity with various neurotic conditions leads the experienced practitioner to a quick and usually correct diagnosis. Less experienced individuals, though, should avoid "snap

diagnoses," for, in the event of error, great harm can result. There are certain symptoms and signs which suggest mental disease and should prompt the inexperienced to seek competent help. The wrong attitude toward a compulsive or depressed patient may drive him away or even result in his suicide. The hysteric quickly takes advantage of any sympathy he can arouse, and is probably best treated with great firmness and perhaps with some brusqueness. The same treatment of an obsessed patient, however, would prove positively harmful.

The recognition of a psychotic state is usually not difficult. The exact type is not important, for the persecution complex of the paranoid, the behavior peculiarities of the schizophrenic, the overboisterousness of the manic, or the gloomy seclusion of the depressive are apparent even to the inexperienced.

The neuroses are less easy to diagnose and, although many are easily recognized, others, especially the psychosomatic disorders, may require prolonged investigation before organic disease can be ruled out.

For the priest, nurse, or social worker, the important states to recognize are the obsessive-compulsive states and hysteria. It seems essential to re-emphasize the importance of their recognition. Great psychic harm can result if these people are treated as normal individuals would be treated. The recognition of the obsessive-compulsive states and of hysteria is greatly facilitated if the patient is allowed to speak freely and uninterruptedly. Most mistakes will be avoided if ample time is allowed for the completion of the story. If such time is not available, however, an immediate judgment need not be given. The patient should be encouraged to come back when more time is available. If the person consulted does not have the time to investigate the condition, the patient should be referred to someone else who has both the time and the ability to do so. Before a final opinion can be given it may frequently be necessary to investigate the background of the story and even to question members of the family or other individuals concerned.

Certain personal characteristics are helpful in diagnosing these neurotic states. The obsessive-compulsive patient is usually poorly dressed, submissive, sorrowful, and persistent. He has analyzed the situation to his own satisfaction even "to the consequences of the consequences." The hysteric, on the other hand, is usually fashionably clothed, egotistic, boastful, and confidential. She is full of stories of narrow escapes from either sin or disease. She sits

close to the examiner and in low, confidential tones discusses her sex life, which she is certain is the source of the trouble. We use the female pronoun advisedly, since the hysteric is most frequently a woman. Abuse of a compulsive patient makes him more submissive and dejected, whereas the hysteric patient usually gets angry, and the normal individual usually reacts by assuming a sullen air.

There are certain symptoms which, while not conclusive evidence of mental disease, suggest the need for further investigation. Much attention has been devoted to the subject of the recognition of mental aberration by the medical boards of the Selective Service. Such recognition is essential because individuals so affected are a source of trouble, and much unnecessary hospitalization is required when they are subjected to the rigors and discipline of military life. Before this difficulty was clearly recognized during the early days of the 1917 draft, many of these men were inducted into the army. The difficulties resulting may be clearly understood from the following telegram sent by General Pershing from France in July, 1918:

Prevalence of mental disorders in replacement troops recently received suggests urgent importance of intensive efforts in eliminating mentally unfit from organization's new draft prior to departure from the United States.

The following list is taken verbatim from "Medical Circular No. 1, Revised 1941," issued by Selective Service Headquarters for the guidance of examining board physicians. These physicians are advised to refer for further examination the selectees who manifest the following deviations: instability, seclusiveness, sullenness, sluggishness, discontent, lonesomeness, depression, shyness, suspicion, overboisterousness, timidity, sleeplessness, lack of initiative, lack of ambition, personal uncleanliness, stupidity, dullness, resentfulness to discipline, nocturnal incontinence, sleep walking, recognized queerness, suicidal tendencies (bona fide or not), and homosexual proclivities.

These symptoms, or neurotic traits, are frequently evidence of a developing or fully developed psychoneurosis or personality disorder.

Differential Diagnosis

It is difficult, at times, to tell whether the symptoms of certain incipient disorders indicate a neurotic or psychotic syndrome. In general, it may be said that the attitude of the person toward his problems counts greatly. His reaction and his insight are most significant. Whether again the entire personality, or only part of

it, is attacked is of importance to the psychiatrist. Of special significance also is the presence of hallucinations and delusions. In Tredgold's words,

The distinguishing features of a neurosis are that the patient retains insight into his condition and awareness of his surroundings, and that while his reaction to these is disturbed, there is no complete overthrow of the personality. The disturbance, moreover, does not affect conduct to the extent of rendering him certifiable and in need of detention although he may be an invalid and unable to follow his occupation. In a psychosis, on the other hand, the disturbance is more profound.³³

DIAGNOSTIC DIFFERENCES BETWEEN THE NEUROSES AND THE PSYCHOSES³⁴

The Neuroses

1. Personality remains intact.
2. Reality discrimination fairly normal.
3. Reality testing not seriously impaired.
4. Thinking fairly consistent with environment.
5. True delusions not present.
6. Associations unimpaired.
7. Trends and motives not abnormally projected.
8. Repression largely maintained.
9. Complexes not often autonomous.
10. Conation only slightly disturbed.
11. Affective changes slight.
12. Herd sense maintained.
13. Regression moderate and controlled.
14. Fact of illness consciously recognized.
15. Social behavior fairly good.

The Psychoses

1. Personality distorted or shattered.
2. Reality discrimination greatly impaired.
3. Reality testing uncritical or absent.
4. Thinking abnormal — even delirious.
5. Delusional thinking common.
6. Associations impaired and distorted.
7. Trends and motives markedly projected.
8. Repression largely destroyed.
9. Complexes largely autonomous.
10. Conation profoundly disturbed.
11. Affective changes great. Lability decreased.
12. Herd sense largely lost.
13. Regression extreme and uncontrolled.
14. Fact of illness when well established not recognized.
15. Unsocial or antisocial behavior developed.

Strecker, in his excellent book, *Fundamentals of Psychiatry*, gives a partial differential between the psychoneuroses and the psychoses as follows:

The psychoneuroses are essentially different from the psychoses. In general, the psychoses involve marked disruptions of personality and total abandonments of reality. In the psychoneurotic, there is much less personality upheaval and disorganization and the hold on the environmental realities is tenacious. The emotional life of the psychotic patient is markedly disturbed, often seriously diminished and sometimes altogether abolished. The emotions of the psychoneurotic patient remain relatively flexible. Psychoneuroses to be sure are maladaptations, but the failure to adapt is partial, and is much nearer to a hypothetical norm than it is to the psychoses. In psychotic patients, in general, insight is incomplete. The psychoneurotic, in very large measure, has the capacity to stand off and look at himself objectively, evaluate his symptoms, and accept and act on psychotherapeutic explanations.³⁵

SUMMARY

The neuroses are the first of the clinical variety of psychiatric disorders to be discussed. These are considered to be defensive reactions utilized by an individual to protect himself from deflating experiences that threaten his ego. They are of psychogenic origin and arise from the defective habitual employment of the intellect, the emotions, and the will. Neuroses must be recognized as real illnesses. The neurotic individual suffers keenly and although his disturbances have a purely psychic or emotional origin they are genuine and in no sense imaginary.

It is generally believed that the soil is prepared in childhood for the development of the adult neurosis. This is in general true, but should not be understood to mean that the origin of the disorder may not be in adult life. The neurotic conflict is seldom in focal consciousness but is usually unconscious (in marginal consciousness). The neurotic symptoms are usually grouped into symptomatic constellations which are clinically grouped under six groups. These are (1) the obsessive-compulsive neuroses, (2) neurasthenia, (3) hysteria, (4) hypochondriasis, (5) anxiety neurosis, (6) reactive depression. These states are described in detail in the next chapter.

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23. *Ibid.*
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32. Noyes, *op. cit.*, p. 283.
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34. Cf. William S. Sadler, *Theory and Practice of Psychiatry* (St. Louis: The C. V. Mosby Co., 1936), p. 454.
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THE INDIVIDUAL PSYCHONEUROSES

In the previous chapter we have discussed the general principles which apply to the psychoneuroses. In this chapter the individual psychoneuroses will be discussed. It would be more proper to speak of symptom clusters because, although it is clinically convenient to consider these conditions as entities, they are actually named after the principal psychodynamic mechanism shown by the patient. In thinking of the psychoneuroses, it is better to think in terms of mental mechanisms rather than in the names of the disorders. For the sake of convenience and for purposes of teaching, giving a name to the symptom clusters is very useful. In describing these conditions we will adhere to the following outline as closely as possible:

STUDY OUTLINE FOR PSYCHIATRIC DISORDERS

1. Definition of the disorder
2. History of the disorder
3. Frequency, or percentage of patients who have this disorder
4. Approximate age on onset
5. Etiology (cause):
 - a) Remote — predisposing
 - b) Proximate — exciting
6. Part played by heredity as an etiologic factor
7. Symptoms, physical and psychic
8. Psychopathology and psychodynamics
9. Treatment
10. Prognosis
11. Differential diagnosis
12. Summary and conclusions

THE INDIVIDUAL PSYCHONEUROSES

Under the heading, "The Individual Psychoneuroses," the following disorders will be briefly treated:

1. Hysteria
 - a) Conversion reaction

- b) Anxiety hysteria
- 2. Psychasthenia
 - a) Phobic reactions
 - b) Obsessive reactions
 - c) Compulsive reactions
- 3. Neurasthenia
- 4. Anxiety reaction
- 5. Hypochondriasis
- 6. Reactive depression

HYSTERIA (DISSOCIATIVE REACTION)

Definition

Hysteria is an ill-defined mental disorder with protean manifestations of psychogenic origin in which a great variety of symptoms may be produced on the basis of an inner conflict whose elements are usually not clear to the individual.

History

The hysterias were the first of the psychoneuroses to be studied scientifically. Freud's original investigation was in a case of hysteria. The word, etymologically, means "womb" and the disturbance was supposed by the ancients to result from a wandering of this organ to the various parts of the body. Sadler speaks of hysteria as an "ancient and honorable disease."¹ Weiss and English² speak of hysteria as one of the least severe and most easily treated of all the neuroses. It is a very common reaction and, although occurring in a great variety of forms, it is probably the most easily understood.

Etiology

As pointed out above, hysteria is the consequence of a marginally repressed conflict. It is generally considered that this conflict is unacceptable in the conscious mind, but gains expression in physical symptoms. As a general rule, it may be stated simply that the individual so affected wants something. This fact remains, whether the hysteria is that of the seaman who becomes paralyzed through fear or that of the bride who faints because she does not get her own way.

Symptoms

The great variety of hysterical manifestations makes any attempted description almost impossible. There is one feature common to all hysterical conditions except in an anxiety hysteria. This is known

as *la belle indifférence*. By this term is meant that the individual, who is apparently affected by a serious disorder, displays toward his affliction a total lack of concern. He will describe his symptomatology as though it belonged to someone else.

The emotional block in the hysterical patient is central rather than peripheral and as a consequence the physical examination reveals intact nerve tracts.

There are certain characteristics of the hysteric which are useful indications of the presence of the condition. He usually "presents himself," or more frequently calls the physician to him, well dressed and self-complacent. He usually tells with great delight his physical ailments; he relates with great detail his narrow escapes. He usually has just escaped death in one form or another. Diseases always affect him more severely than they do others. This information is frequently given in low tones which almost necessitates contact between the two parties. The slightest criticism is apt to bring quick resentment. Changes of mood are frequent and truth is of minor consequence. He seems not to be influenced by shame, but seeks merely how best he may get what he wants. If no better way is found to achieve his aim, he will get sick or have a convulsion or an hysterical faint. If he does have a convulsion, he takes care not to hurt himself in falling as an epileptic is apt to do. He will never have such an attack without an audience. *Hysterical fainting* is quite common. This also follows a typical pattern. It is hard for those near to the patient to recognize the nature of the attacks. When they do, the patient changes to another method. When seen in a faint, the patient usually has fallen into the most comfortable chair or couch in the room, is lying stretched out with clothes neatly arranged, eyes closed, and hands crossed on chest. The breathing, color, pulse, blood pressure, and skin are all normal. He can be quickly roused by a sufficiently painful stimulus such as pressing over the supraorbital nerve or sometimes by merely mentioning the use of a painful treatment. The hysterical nature of the condition may be demonstrated by disarranging the clothing of the patient and then insisting that everyone leave the room. Upon returning after some minutes, the clothing is usually neatly rearranged. The conversation of the hysteric usually deals with himself as a topic. There is frequently a tendency to expound on his sex life. Although extremely egotistical, the hysteric is usually highly gifted and intellectually stands high. Because it is much harder to fool the older, more experienced men,

there is a tendency for the hysteric to seek out the younger doctors in whom he is more likely to arouse sympathy.

CASE 16: *Hysterical Behavior*

Christopher's home was a very affectionate one, with the exception of his father who was disappointed in him because he would have liked a more manly sort of son. His mother and sisters lavished affection on him, and he soon learned that when their manifestations were not sufficiently in evidence, a timely tantrum produced immediate results in pampering, coddling, kisses, and expressions of love. In his early school days he found that an illness would extricate him from an unpleasant situation and used this mechanism to avoid school. However, the resulting failures were unpleasant, so he resorted to dishonest means of getting through examinations. He learned best those subjects that made an outward show: he became an excellent penman, a rapid typist.

At boarding school during his college years, this tendency became more pronounced. There, surrounded by men and boys, the affection and attention to which he was accustomed were harder to obtain. He again resorted to simulated heart attacks and fainting to extort from the men with whom he lived some manifestation of care and solicitude. Perhaps despairing of obtaining affectionate manifestations, he turned his mind to working for attention. His room became known among his associates as "The Bucket of Blood," from the lavish use of red paint that Christopher indulged in. The paintbrush swept from the floor to the ceiling, passing on its way the bed, dresser, bookstands, and chairs—not even missing the bedroom slippers that he wore. He plagiarized a short story that was not well known, but had been published, and with this contribution he won the gold medal in the school for the best short story. He wore the medal as proudly as if he had earned it, even after the facts leaked out.

On his own admission, this boy entered a religious community chiefly because his teachers had spoken disparagingly of it and he wanted to startle them. He was successful in startling not only his former teachers, but his whole family, including himself. However, although he began to realize that it was a serious business, the life was novel enough at first to interest him, and he found many ways of giving play to his spirit of "dare to be different." His habit was always a little longer and more flowing than the other men's; his cincture was just a little wider; his collar was fastened in a different manner. While in this community, he begged to be moved from the "B" division of the class to the "A" on the

plea that he was so stifled by the humiliation of being placed in the "B" class that he could not do work that was really representative of his ability. He rode through the "A" class on a "pony" with fair success.

Since he was actually inferior intellectually, he was finally exposed with regard to his dishonesty, faked faints, and an abnormally high temperature which was so conveniently brought on that the doctors in attendance are still wondering how it was done. The humiliation of this exposure, combined with his realization that he could never actually live the life of a religious, prompted him to give up his "vocation."

With practiced skill, he successfully used his time-honored methods to obtain a degree at a public university, after which he taught for a couple of years. Since among his new associates the Catholic faith was scoffed at, he abandoned it. They were not too greatly impressed by this action. He now tries to impress his Catholic friends by refusing to genuflect before the Blessed Sacrament and by bragging that he has lost his faith.

By way of comment on the above we may observe: (a) As a child, Christopher was confronted by the problem of insufficient affection. He solved it by tantrums and got what he was after. (b) In early school days, he found school tedious. He worked out a solution by assuming sick spells. (c) Boarding school did not bring the desired attention. He solved this problem by "heart attacks" and fainting spells. (d) His intellectual dishonesty and inferiority created a problem which he parried by assuming fainting spells and high temperature. Of course, if Christopher were really just faking his symptoms, as sometimes happens, his would not be a true hysterical picture. *Deliberate and conscious faking is known as malingering.* There was undoubtedly some of this in Christopher's case also, but the physical symptoms of illness, fainting, palpitation of the heart, and high temperature were hysterical reactions.

The motives for hysterical conduct influence the patient but are not in all respects clear to the individual. The soldier who becomes hysterically blind in the sighting eye because he wishes to avoid war is not aware or does not allow himself to realize consciously that such a motive dictates his physical state. It is difficult for some to understand and admit this. But students of hysterical phenomena, no matter what their philosophy, agree unanimously that hysterical behavior is prompted by motives of which the subject is not clearly aware. If directly accused of deliberately deceiving, or if told that

the symptoms of disease have been arbitrarily assumed, the hysteric often shows resentment or feels deeply wounded. Though the practitioner is correct in realizing the evasive and often futile nature of conversion in neurotics, it should never be considered or treated as deliberate deception.

Another significant feature of the somatic symptoms assumed by the hysterical personality is their *purposefulness*. Their prime purpose is to solve conflict. Such solution must be graceful, honorable, and as imperceptible as possible. Specifically, there are as many reasons for the presence of somatic symptoms as there are types of conflict. The purpose of the assumed cardiac disturbance of the hysterical soldier is to remove him from facing the hardships of battle or military life and to do so honorably. Painful conditions may be developed by the laborer to bring him honorable relief from the drudgery of the factory. Hysterical amnesia and fugue will provide relief to a husband weary of marital discord. The purposefulness of the somatic symptoms of hysteria is not formally appreciated by the patient. Because of the life of escape, evasion, or defense previously developed and because of the emotional and mental habits characteristically present in the hysterical personality, such a state of affairs is possible. It is very important and often extremely difficult to discover the express purposes motivating hysterical conduct. The patient is generally unwilling and often incapable of rendering effective assistance in the search.

Other Manifestations of Hysteria

1. *Fugue*. An hysterical *fugue* is a manifestation of the condition in which the patient escapes from reality in the sense that he becomes unmindful of his environment and often of himself. Strecker and Ebaugh define a fugue as "a state during which the patient for a certain period of time seemingly acts in a conscious way, perhaps travelling, buying food, and, in general comporting himself in a natural manner; yet afterward he has no conscious remembrance for this period of time and his behavior during it."³

2. *Amnesia*. Amnesia means loss of memory and, although frequently hysterical, may result from a variety of causes. Leavitt reviewing 12,000 hospital admissions found a total of 104 cases of amnesia, approximately 1 for each 120 admissions.

Hysterical amnesia is usually assumed in an effort to escape from an unpleasant experience. In such instances it may be quite selective

and the individual may be able to recall all of his past experiences except those directly related to the psychic trauma.

3. *Writer's cramp*. This is a condition in which persons engaged in specialized work develop an inability to perform the neuromuscular action involved and the individual so affected is able to perform any muscular action except those directly concerned with the work, i.e., a bookkeeper may be able to perform anything necessary to this occupation except to sign his name.

4. *Somnambulism, sleep talking, night terrors, and nightmares*. In most instances, these are hysterical in origin.

5. *Stuttering or stammering*. This is usually considered to be neurotic in origin and is frequently hysterical.

6. *Convulsions*. Although hysterical convulsions are usually easy to recognize as such, there are many instances in which the differential diagnosis between epilepsy and hysteria may be very difficult. (See "Epilepsy," p. 515.)

CASE 17: *Hysteria*

This patient, 29 years of age, was admitted to the hospital because he had been found unconscious and having convulsions. He was aroused within ten minutes and shortly thereafter had another attack which endured for eight minutes, but during which the pulse was full and regular. He returned quickly to consciousness, but his left arm was numb and the left handclasp was weak. The following day he was "nervous, weak, tearful, and quite restless."

On admission to the hospital, he complained that he could not gain his strength and had frequent "nervous spells." The history revealed that he had always been a moderately "nervous" individual who concealed his emotions and made every effort to cover up his timidity and fearfulness. His mother had frequent "nervous spells" and a quick temper. His father died after three years in a hospital, following a paralysis of the left side which was accompanied by strange behavior, including one or two efforts to kill his wife. The patient had been afraid that his life would follow the pattern of his father and believed that his symptoms might represent an illness similar to his father's.

Physical, neurological, and routine laboratory examinations were essentially negative. The neurologist reported that there was insufficient evidence to give the diagnosis of epilepsy to the patient's symptoms. Mental examination showed an ingenuous, suggestible individual who seemed more concerned with the dramatic features of his illness than with its medical significance. He greatly over-

estimated his abilities and minimized or obscured any personality trait which might be considered unfavorable. While in the hospital, he showed no improvement.

Classification

From the preceding remarks it is evident that it is more proper to speak of the hysterias than to refer to a specific disorder. For that reason hysteria is usually divided into (1) *conversion hysteria* and (2) *anxiety hysteria*.

1. *Conversion hysteria*. By this term is meant the change or conversion of the psychic conflict into physical symptoms.

Conversion hysteria is described in the *Statistical Guide* as follows: "Cases should be classified according to the subgroups under this general heading. The symptoms to be found in these various types are indicated in the classification for guidance in differentiation and are self-explanatory. It is to be recalled, however, that some of these hysterical symptoms may occur in the psychoses, and by themselves are not diagnostic; the whole clinical history and picture must be considered" (002-x10 Conversion hysteria).⁴

Symptoms of conversion hysteria. This conversion may produce a great variety of symptoms:

a) Sensory symptoms, i.e., anaesthesia, blindness, or deafness. Any of the senses may be affected.

b) Motor symptoms, i.e., tics, paralyses, stuttering, or any other motor disturbance.

c) Vasomotor symptoms, e.g., blushing, localized erythemas, cyanosis.

d) Visceral symptoms — a great variety of visceral symptoms may be produced. The gastrointestinal tract is most susceptible.

e) Mental symptoms, i.e., amnesia, sleepwalking, fugue, delirium, and similar conditions.

2. *Anxiety hysteria*. When the predominant manifestation of the hysterical state is overt anxiety, the condition is usually referred to by this term.

There is not complete agreement on what should be covered by this designation. According to one viewpoint, anxiety hysteria is conversion hysteria with anxiety added to the clinical picture. From another viewpoint, anxiety hysteria includes those reactions which are indicated in the present classification under "Psychasthenia, phobia" (002-x23).⁵

From still another viewpoint, anxiety hysteria is not a desirable

designation and all reactions which have been previously designated as anxiety hysteria are, according to this viewpoint, more properly classified as anxiety states 002-x33).⁶ (*Statistical Guide*: 002-x00.⁷)

OBSESSIVE-COMPULSIVE REACTIONS

Under this heading are to be classified those cases showing predominantly obsessions, compulsions, tics and spasms, and phobias. These conditions were formerly grouped under the term "psychasthenia."

Definition

This state is described by Muncken as consisting of "ideas their bearer recognizes as logically abnormal, odd, absurd, unreasonable, or at least lacking in solid foundation, but which, nevertheless, because of the agonizing emotions accompanying them dominate consciousness, are forever foisting themselves upon the mind in spite of all opposition, and seek to drown out the voice of reason and to force recognition." Muncie gives a shorter but very similar definition. He says that it consists of "insistent ideas, thoughts, words or actions which may not be voluntarily controlled and demand reiteration in order to ease the feeling of tension."⁸

The term "psychasthenia" for these conditions was originally introduced by Janet.⁹ Etymologically, it signifies a weakened condition of the mind. In its present usage psychasthenia is occasionally employed to designate a group of psychogenic mental disorders, including states of hesitation, doubt, phobias, obsessions, and compulsions founded on pathological fear.

Etiology

Sadler¹⁰ vouchsafes the opinion that obsessive-compulsive reactions are largely hereditary and designates those suffering from them as "neurologically disinherited," saying that most psychasthenes are "born, not made." This opinion is unacceptable and not widely held. These reactions are disturbances principally of the immaterial intellect and are not per se subject to hereditary transmission. These states are essentially fear states, and scientific evidence indicates that fear is acquired, not innate. Moreover, extensive analysis of case histories reveals that fear states are acquired during the lifetime of the individual possessing them. Acquired traits are not hereditary. The case against inheritance as a cause of psychasthenic states is strong.

Freud thought that obsessive-compulsive reactions resulted from the repression of sexual desires or motives. Janet considered them to be the

result of the lowering of psychological tension. These opinions are no longer generally held.

Fear-provoking events of all kinds, such as unexpected explosions, contact with a corpse, sight and touch of snakes, fires, falling in the water, information concerning tuberculosis, cancer, and syphilis, *may often be the occasion or precipitation factor of prolonged, painful fear states*. Such events of themselves do not cause psychasthenic states. All people undergo such experiences, but only in a relatively small percentage of cases do phobias or compulsive urges result. The basic and important question is why do such events precipitate psychasthenic states in some minds and not in others. The answer would seem to be that personalities which have been previously disposed to fear reactions by habitual indulgence succumb more readily to psychasthenia. There is no known force which compels people to develop phobias, obsessions, and compulsions. Accidents, death, horrifying incidents will leave some minds untouched. Such events do not produce or precipitate a fear state unless the soil has been carefully and systematically prepared. Preparation of this kind may be supplied by previous faulty training, such as a childhood spent living in fear or overprotection by fond parents.

Even in such predisposed mentalities, psychasthenic trends do not develop into pathological, fixed states unless by frequent repetition, repeated indulgence. Skillful counselors, prudent parents, and educators possessed of such knowledge can do much to prevent the development of painful fear habits by preventing this repetition in children and young people.

Compulsions and obsessions are usually symbolic of an underlying sense of guilt. Such a feeling of guilt is usually vague and in many instances so deeply buried that its cause cannot be easily elicited. The obsession or compulsion is symbolic and may have no direct significance as far as the original source of the guilt is concerned. In some instances, particularly in the hand-washing compulsion, there is a fairly direct relationship. Such a connection may be seen in the case of a 26-year-old white woman who sought advice because she spent so much time washing the baby's clothes and bottles and washing her hands before preparing his food that she had no time to do any other housework. Before preparing food for the baby, it was necessary to boil all the utensils for at least twenty minutes, two or three times. She would have to wash her hands five or six times before touching the baby and then if she touched any other

object this would have to be repeated. No one else was allowed to touch the baby, and if anyone did, the mother became extremely anxious for fear that he would develop some disease and die. Investigation of the patient revealed that this was her first and unwanted child. During the early days of her pregnancy, she had hoped that she would abort, and when she did not, she developed some fleeting hopes that the baby would die at birth. She reacted to these thoughts with marked guilt and they were immediately repressed. On the birth of the baby she reacted to this repressed guilt by becoming extremely overconcerned in regard to anything which might affect the baby's health. (See "Case of Obsessive Practice Based on a Fear of Fire.")

Symptoms

1. *Physical manifestations.* Although the patient is quite likely to show somatic manifestations, these are not, as a rule, characteristic. Those most likely to be present are the physical manifestations of prolonged fear. There is present in all cases a severe subjective sense of fatigue which is undoubtedly due to the underlying emotional struggle and is in no way warranted by the patient's activity.

2. *Mental manifestations.* Pathological prolonged fear is the dominant emotion. All variations of fear may be present in varying degrees. Worry, anxiety, dread, and apprehension are common. The fear expressed by these patients is subjective in nature and unwarranted by its apparent stimulus.

a) Excessive introspection is an almost universal mental trait of this condition. The patient is constantly watching and studying his physical, emotional, and mental activity.

b) Certain personality traits predispose to the development of this disorder. These characteristics, usually described as those of the *rigid personality* (q.v.), are similar to those found in the individual who develops involutional melancholia. Other characteristics of these psychasthenic individuals which may be mentioned are extreme conscientiousness, overexactness, overcleanliness, dislike for handling other people's money, self-pity, and indecisiveness.

Varieties of Obsessive-Compulsive Reactions

1. Phobias
2. Obsessions
3. Compulsions

1. *Phobias.* *Phobias are habitual irrational fears usually of a definite entity associated with an undue degree of anxiety and unwarranted by objective facts.* *Phobia* is the Greek word for "fear," and a great variety of terms is used to indicate specific fears, i.e., claustrophobia, or fear of small spaces; agorophobia, or fear of open spaces; phobophobia, or fear of fear. It would seem better if the term "phobia" were dropped entirely and the word "fear" were used in its place. This would not only save misunderstanding, but would ease the mind of the patient in whom sometimes the high-sounding Greek name of his fear produces as much distress as the fear itself. The most important element of the fear reaction is its intellectual aspect. Man alone has phobias. In man phobias are like the instinctive fears of an animal, but differ from them in one important respect. In animals, fear states are entirely sensory reactions; in man, they are intellectual reactions.

Phobias are often intense and paralyzing. The mere thought of the feared object is sufficient to create a reaction. Patients carefully avoid discussing their fears and make every effort to avoid coming face to face with the object of their fear. Characteristically, they recognize the subjective and irrational nature of their reactions, but no amount of logic or argumentation is effective in changing their attitude.

As originally pointed out by Freud, phobias may be divided into two groups: (a) an exaggerated fear of those entities which are by their nature fear provoking; and (b) fear of objects which are not usually considered fear provoking.

CASE 18: *Fear of Insanity*

Philip, aged 32, was happily married and had two children. He was one of a corps of accountants maintained by a large Mid-western railroad. One Sunday, while attending church services with his wife and children, he was inexplicably overwhelmed by a fear that he was going insane. The more he attempted to pray or give his attention to the services, the more oppressed he became by the terrifying thought. He became pale, agitated, and weak. He interpreted these phenomena as part of the process of losing his mind. Fellow churchgoers, thinking he was ill and in danger of fainting, urged him to leave the church and helped him to a chair in the vestibule. He soon began to feel better and by the end of the services was sufficiently recovered to take the streetcar home with his family. Once outside in the fresh air, he felt better

and breathed a sigh of relief at finding himself still sane after so close a brush with the "hideous monster of insanity."

Everything went fairly well during the week, though he felt somewhat shaken. On the following Sunday, the family once more set out for church. As they approached the edifice, Philip began to experience feelings of uneasiness and fear that he might again undergo the experiences of the preceding Sunday. Once inside the church, he again became oppressed by the feeling that he was going insane and knelt down hurriedly in the back and soon bolted for the door. After one more experience of this kind on a third Sunday, he resolved to stop going to church in the interests of his sanity.

Some weeks later when working at his books in his office on the thirteenth floor of a large building, he again became paralyzed with fear that he was losing his mind and was sent home by the office manager who thought he was ill. Later on, these incidents increased in number and intensity. He knew no basis for his fear, nor could he assign any for the paralyzing paroxysms of fear that seized him ever more frequently.

CASE 19: *Fear of Closed Places (Claustrophobia)*

An immigrant, aged 65, suffered all his life from an intense fear of closed places. The beginning of the phobia could not be traced, and there was little hope of improvement. Born and raised in the country, he found it difficult to adjust himself to the confinement of city life. His occupation required considerable travel, and he found Pullman berths intolerable. He often took long journeys and tried sleeping in berths, but in a short time he began to suffocate, gasp, perspire, and would be seized with panic. He could only find relief by sitting up in the chair car. He experienced similar, though not such extreme, reactions in elevators. He would much prefer to walk twenty stories rather than ride. He could not stand movie theaters. While the lights were on, everything seemed all right, but when the lights were extinguished, he experienced the sensation of being locked in an insufferable black hole.

CASE 20: *Fear of Germs*

A married, well-educated gentleman of 50 was obsessed by a fear of contamination from germs. Though married, there were no children, and the couple spent their lives in a hotel of which the man was part owner. He was efficient as an office manager, but extremely squeamish. Before beginning to work at the office, he spent considerable time cleaning the office and cleaned his

desk with a cloth saturated with some germicidal preparation. He spent hours brushing his clothes. He ate at only one restaurant which he selected after careful inspection of the kitchen, and ate only a limited number of foods. He disinfected doorknobs with a carefully prepared handkerchief which he carried with him. If, while sitting at his office, in the hotel lobby, restaurant, theater, or church, someone brushed by him too closely, he would take off his coat to brush off any migrant germs. He was a Catholic but refused to use the public holy-water font at the church and carried his own private supply.

2. *Obsessions.* An obsession is an overpowering, persistent, and irrational idea accompanied by feelings of tension and fear. From the conscious standpoint of the patient, the obsession is uninfluenced by logic and is distinctly unwanted.

Phobias and obsessions are closely related inasmuch as all obsessions are phobias and all phobias are obsessive. The latter adds to the former a note of mental preoccupation with the object feared. The two states are practically inseparable, i.e., those who have a fear of cancer are in reality obsessed with the idea. The thought of cancer is constantly before their minds. The fear element is phobia, the thought element is obsession.

Types of obsessions: As in the case of phobias, almost anything can become the object of an obsession: (a) sexual obsession, i.e., the inability to eliminate thoughts of sex or sexual perversions; (b) irremovable thoughts of blasphemy, sacrilege, and loss of faith (commonly known as religious scruples); and (c) persistent thoughts of murder, suicides, and maltreatment of others or oneself.

CASE 21: Obsessive Practice Based on a Fear of Fire

A young college student living in a college dormitory became mildly obsessed with the idea that he had neglected proper precaution and that his private room was on fire. One night after class he had returned to his room and there saw evidences of how narrowly he had missed setting the whole building on fire. On leaving the room he had abstractedly laid a burning cigarette on a piece of marking tape loosely spread across his disordered desk. On one side were stacked a highly inflammable pile of loose papers and themes across which lay one end of the tape. The cigarette ignited the tape on the other side of the desk, and the passage of the fire was stopped by a closed box of matches inadvertently placed on top of the tape just before it reached the paper. The possibilities

of what might have happened overwhelmed the student as he realized his good fortune. For years afterward, he could hardly leave his room before his mind would be obsessed by the idea that he had not extinguished his cigarette and that the room was on fire. He would hastily and abruptly leave meals, class, church, recreation, or wherever he happened to be, and rush to his room.

CASE 22: Counting Obsession

A doctor in mathematics from a leading university of the country was obsessed by the urge to count telephone posts and the number of windows in the building. Even when walking and discussing with others, he could not resist the urge to count the passing posts. Of course, it was very difficult to do both, and on occasions he became so interested in the conversation that he lost record of the count, became interiorly agitated and distressed, and could only satisfy himself by going back and beginning over again. This happened more than once. He has reduced the number of embarrassing incidents by using a small hand counter.

3. *Compulsions.* A *compulsion is an overpowering, unreasonable urge to perform certain actions and is associated with the development of tension or anxiety if the act is not performed.* It is an act contrary to the conscious will of the subject at the time the act is performed.

Compulsions differ from obsessions and phobias inasmuch as they are not confined to thought processes, but lead to overt activity.

Types of compulsions: The variety which compulsions may take is so great that it is impossible to enumerate all of them. Some of the more common are:

Symmetry complexes in which everything must be perfectly balanced. If the house is entered or approached on the right side, the patient will not be satisfied until the same act is repeated from the left side. If, inadvertently, one rubs his cheek, the other cheek must be rubbed.

Dressing and undressing rituals, in which a person may dress three or four times in a morning until the job is exactly performed according to some peculiar, subjectively formed set of rules.

Overpowering forces which sometimes assume an asocial nature. The most common of such compulsions is kleptomania, an overpowering irrational urge to steal any type of articles which usually are of little value or use to the individual.

Pyromania, which is an irrational, overpowering urge to set fires.

Sometimes this is a manifestation of some other irrational or psychotic state, but it may also be a true compulsion.

Hand-washing or cleanliness compulsion, in which the patient feels compelled to wash his hands frequently. This may progress to a point at which the patient attempts to open doors with the back of his hands so as not to dirty the palms. Noyes mentions a woman who would go to church the night before services to wash the seat which she would occupy.

CASE 23: *Compulsive Acts*

This 24-year-old white male, while on overseas duty, began to show marked symptoms of confusion, panic, and gross tremors of the hands. He attempted to remain on duty but was referred to sick bay and shortly afterward was admitted to the hospital. Mental examination, together with observations on the ward, showed him to have obsessive ideas, which impelled him to carry out compulsive acts. He had a decided fear of germs and made a ritual of washing his hands at frequent intervals throughout the day. At other times he was compelled to open doors with the back of his hands in order to avoid contact with the doorknob on his palms. He was overly conscientious, quiet, and fastidious in his speech and personal attire. With all of these there was apprehensiveness together with a mounting tension which occasionally produced a panic state with weeping. He was of superior education and intelligence and had a fair degree of insight which enabled him to freely verbalize his feelings and past history.

It was learned that he came from a superior home in which standards of conduct and moral codes were very high. The patient had been carefully reared from earliest infancy. His toilet and other habit training had been rigid with strict attention to cleanliness. He had always been a quiet, conforming child, overly conscientious, and had experienced a strong sense of guilt over the most trivial misdeeds. He stated that life in the service with its high standards of cleanliness and regulations of conduct had given him a sense of security for a time, but had gradually reinforced his conflicts. He began to give more and more attention to minute details with the resulting break in general performance noted above.

Prognosis

Obsessive compulsive reactions are among the most difficult of the psychoneuroses to treat. In severe cases it is doubtful that the patient ever fully recovers. In those cases in which the source of the difficulty

can be elicited, the prognosis is somewhat brighter. In most instances, the best that can be expected is that the patient may learn to live with his disorder.

NEURASTHENIA

Definition

*Neurasthenia is a disorder of psychogenic origin, characterized by a severe subjective sensation of physical fatigue and a feeling of inability to carry on.*¹¹

Etymologically, the term "neurasthenia" signifies a condition characterized by "neural weakness." It is one of the most widespread of the psychoneuroses. It is estimated that from 6 to 8 per cent of the entire population suffer from this disorder. Walsh¹² calls it the "American disease," an appropriate title. Neurasthenia is described by the *Statistical Guide* as follows: "To be designated under this heading are those cases in whom organic disease is ruled out and who complain of motor and mental fatigability, diminished power of concentration and pressure in the head, scalp, neck, or spine. Early dementia praecox or mild depressions of the manic-depressive type not infrequently have to be considered in the differential diagnosis" (002-x30).¹³

Etiology

Overwork has long been considered an important causative factor of neurasthenia. Recent opinion, however, is almost unanimous in opposing this view. Work done under pressure or accompanied by anxiety may frequently result in neurasthenia. The important factor here is the emotional stress and not the physical work. Sadler¹⁴ thinks that the principal contributing cause of the neurasthenic states is an "inherited taint" together with psychic factors. Heredity has nothing to do with neurasthenia, and Sadler¹⁵ himself says as much when he writes that neurasthenic states are acquired and not inherited. Freud and his followers attributed neurasthenia to excessive masturbation and nocturnal emissions. Although sexual problems are often present in neurasthenia, it is doubtful if they are causative.

Neurasthenia is a psychogenic disorder which is based on faulty personality development. This includes:

- a) Habitually defective or shortsighted goals;
- b) Habitual unwillingness to shoulder the burdens of life;
- c) Habitual defective attitudes toward problems; and
- d) Habitual lack of self-control.

Symptoms

1. *Somatic symptoms.* Fatigue unwarranted by the physical activity of the patient is the outstanding somatic symptom of neurasthenia. Besides fatigue, he may complain of a great variety of vague somatic symptoms which most commonly affect those systems of the body most difficult to examine, i.e., headaches and menstrual disturbances. Sexual disturbances such as impotence, premature ejaculation, and frequent nocturnal emissions are common.

2. *Psychic symptoms.* The emotional state is characterized principally by a feeling of frustration and mild depression. In association with this may be found (a) hypochondriacal preoccupation, (b) chronic worry, and (c) irritability and emotional hypersensitivity.

The neurasthenes are characterized by lack of will power which expresses itself in the inability to meet the problems of life and unwillingness to make the sacrifices necessary to face reality. Introspection is present to a pathological degree.

It is important in the differential diagnosis of neurasthenia to distinguish between physical and psychic fatigue. Physical fatigue may be produced by overwork, long hours of mental and muscular tension, and insufficient sleep. Such fatigue is easily relieved by proper rest. Such physical fatigue was the cause of the condition known as *combat fatigue* which was so frequently seen during World War II. Even though such physical fatigue is accompanied by physical strain and temporary conflict, it should not be considered neurotic. When such fatigue arises in the absence of fatigue-causing factors or when it continues after the real causes have been removed and becomes an habitual state of mind, the condition is properly called a neurosis.

CASE 24: True Combat Fatigue

A 20-year-old male was admitted to the hospital because of excessive fatigue. He participated in three major campaigns and was twice wounded in action. After the first campaign he became mildly restless, had some difficulty in sleeping, and began to lose weight. During the next two operations his symptoms became progressively worse, and in addition he became moody and irritable with his comrades, developed an exaggerated startle reflex, jumping at all unexpected noises, and had catastrophic nightmares in which he was being attacked by hordes of the enemy. He continued to lose weight until he was thirty pounds underweight. He had frequent severe headaches and was unable to rest. Family history and past personal

history were entirely negative for any emotional or mental illnesses. The patient was sensitive as a youth, but had no specific neurotic traits prior to the onset of his present illness. He stated that he had never felt nervous before his battle experiences.

Prognosis

The prognosis is good in those cases in which the etiological factor can be discovered and removed. Where the condition is due to habitually defective attitudes toward life, therapy is not likely to be very effective.

ANXIETY REACTION

According to the *Statistical Guide* (002-x33), "cases which show more or less continuous diffuse anxiety and apprehensive expectation, with paroxysmal exacerbations associated with physiological signs of fear, palpitation, dyspnea, nausea, diarrhea, are to be classified here. Emotional tension is apt to be high, and irritability and intense self-preoccupation may be prominent, particularly during episodes. The diagnosis should not be made until all other more clearly defined types showing anxiety as a symptom have been excluded."¹⁶

Definition

An anxiety reaction is a condition of mind characterized by an abnormal degree of fearful anticipation of things or events which are merely remotely probable. It is characterized by an habitual unfounded reaction of fear, apprehension, or morbid dread. It may be acute or chronic.

Varieties of Anxiety Reactions

Anxiety may occur in the patient as either (a) *fixed anxiety* in which the fear is attached to some definite object, or (b) *free-floating anxiety* in which the anxiety does not seem to be attached to any definite object. The following variations of anxiety states are usually described:

1. *Anxiety attacks.* In this condition there appear apparently unprovoked attacks of anxiety. These may take place at any time of the day, but are more frequent at night. Usually the patient awakens suddenly and finds himself overwhelmed by an inexplicable sense of fear. Associated with this emotional reaction are various somatic manifestations such as palpitation, precordial pain, dyspnea, and perspiration. Such attacks are frequently mistaken by the patient and his physician for attacks of paroxysmal nocturnal dyspnea and lead to a

mistaken diagnosis of heart disease. Although at first glance these seem to be attacks of free-floating anxiety, closer investigation will usually reveal an emotional problem.

2. *Worry*. In general, worry designates a chronic state of fear. Most people become anxious and fearful at times for objectively valid reasons. Such reactions are normal. In those individuals who become subject to worry, this reaction of fear has become habitual and there is a persistent tendency "to cross their bridges before coming to them."

3. *Tension states*. Chronic states of anxiety are frequently manifested by the development of muscular tension. Such tension may affect both the voluntary and the involuntary musculature. In the first instance, it may result in arterial hypertension, and in the latter instance it may be the source of various muscular pains, the most common of which are an occipital headache or a low back pain.

4. *Anxiety hysteria*. This condition was previously described under hysteria. It is a form of hysteria in which the conversion manifestations are primarily those of overt anxiety.

5. *Anxiety equivalents*. These are states in which the anxiety is manifested as a physical symptom instead of being experienced as an emotion. The equivalents may take a great variety of forms, such as sudden attacks of diarrhea, profuse perspiration, and dizziness. When such an equivalent is present, the patient does not experience any feeling of anxiety.

Etiology

The erroneous solution of a psychic conflict is the cause of an anxiety state. Although the usual factors of heredity and disturbed physiology have been suggested as etiological factors, the consensus is that anxiety states are psychogenic in origin. Strecker and Ebaugh¹⁷ are of the opinion that anxiety in adolescence is a reaction to the problems and uncertainties of that period. Moore¹⁸ considers the defective early training of the child as the source of adult anxieties. Fisher¹⁹ has evolved his own theory of the causation of neurotic anxiety, but admits that the habits formed in childhood are important. Many other authors have the same or similar opinions. Theoretically, many of these writers hold to a variation of materialistic psychology, but fortunately they abandon such fallacious *a priori* philosophical assumptions when confronted with the actual facts. The following case is undoubtedly of psychogenic origin, although the physical problems involved are very pronounced. Such physical factors as delayed puberty and small stature are not *per se* causative factors in the development

of an anxiety state. At the most, they are occasioning or precipitating factors.

CASE 25: Anxiety Reaction

This patient, 22 years of age, complained of "nervousness," worry regarding his physical and mental health, self-consciousness regarding his too youthful appearance, high blood pressure, and extreme restlessness. Later, on admission to a hospital, his complaints were the same. History of the case showed that he had always worried regarding his physical appearance, for, as a child, he was frail and because of this his parents were overly protective. After the age of 17, he grew five inches in height and now states he has always been "just skin and bones." Puberty was delayed until between his sixteenth and seventeenth year, and while in school he was self-conscious and was occasionally "ribbed" because of his lack of masculinity. To the present time he does not have to shave. He has always been submissive, has never had a real fight, and, when he becomes angry, he keeps his troubles to himself and "gets upset." He has been worried by the fear of high blood pressure since his initial physical examination at which time it was necessary for him to rest to "get down to normal."

Physical, neurological, and routine laboratory examinations were essentially negative except for a labile blood pressure which on repeated readings averaged 135/86. Mental examination showed a tall, aesthetic male who appeared several years younger than his chronological age. He was friendly and co-operative, but appeared tense and apprehensive throughout the interview. He spoke freely with appropriate emotional reaction, in a hyperfluent and often digressive manner. There was no evidence of psychosis, but he evidenced a hypochondriacal self-concern, which, in some instances, resembled a phobia regarding his physical and mental health. He was of average intelligence, but self-confidence was markedly impaired.

He stated that he enlisted in the service as an aviation cadet, but was disqualified because of a history of gonorrhea, tremors of the fingers and tongue, excessive irritability in response to superficial stimuli, and because he was extremely "nervous" during the interview.

Symptoms

1. *Physical manifestations.* The physical manifestations of anxiety are the physical manifestations of fear. They result from overactivity of the autonomic nervous system. Some of the more common physical manifestations of anxiety are palpitation of the heart, dyspnea, feelings of suffocation or of choking, dizziness, tremulousness, feelings of faint-

ness, anorexia, startle reaction, excessive perspiration, cold extremities, constipation or diarrhea, nausea, vomiting, dyspepsia, insomnia, and muscular tension.

2. *Psychic manifestations.* *Habitual and painful anxiety, manifested by chronic worry and the presence of vague shifting fears, is the most common manifestation.* Startle reaction, which is characterized by oversensitiveness to noise or other sudden changes in the environment, depression, hypochondriasis, and pessimism are frequently present.

Mild paranoid delusions are not uncommon. Slight confusion, absent-mindedness, and defective memory are frequently present. Preoccupation with fears frequently results in inattention and defective ability to concentrate. Characteristic is the extreme self-interest of the patient which causes him to be concerned only over how he, himself, is likely to be affected, rather than those near and dear to him.

Prognosis

The prognosis in anxiety states depends largely on the ability to determine the conflict giving rise to it and its duration. The shorter period of time the symptoms have been present, the better the prognosis, provided the etiological factor can be removed.

HYPOCHONDRIASIS

The *Statistical Guide* (002-x31) states: "Under this heading are to be classified those cases that, without other symptoms of a psychosis or psychoneurosis, show essentially an obsessive preoccupation with the state of their health or of various organs, with a variety of somatic complaints which are not relieved by demonstration of a lack of pathology. Occurring frequently in the involutional period, they are to be differentiated from involutional melancholia by the absence of marked depression with agitation and self-condemnation. Hypochondriacal complaints may be a symptom of dementia praecox and this reaction type should be eliminated before classifying cases here."²⁰

Definition

*Hypochondriasis is a disorder of psychogenic origin which manifests itself as a morbid concern over the state of the health.*²¹ This usually manifests itself as anxiety. It differs, however, from an anxiety state in the fact that, in that condition, there is actually a disturbance of function due to the overactivity of the sympathetic nervous system; whereas, in hypochondriasis, the patient is conscious of the normally

functioning organs. Such patients may be aware of the beating of their hearts or the movements of their intestines, when there is no demonstrable disturbance of function. The name of this condition is derived from the upper part of the abdomen (hypochondria) which was formerly considered the seat of the disease.

Etiology

Hypochondriasis is psychogenic in origin and is based on an unconscious conflict. Many factors have been considered as possible causes or occasions. Among these may be mentioned parental desire to keep children near them; parental concern over the health of their children; desire to retain privileges obtained during a period of actual illness; unwise investigation into medical literature; unwise remarks or improperly understood statements of physicians; medical mismanagement; insecurity; lack of affection. It may also be the source of subconscious pleasure in masochistically inclined individuals, in whom, because of the obscurity of their symptoms, repeated and painful examinations are required.

Symptoms

Any part of the body may be the site of hypochondriacal symptoms. Physical examination as a rule reveals no evidence of abnormality such as may frequently be detected as a result of overactivity of the sympathetic nervous system in other psychoneurotic disorders.

CASE 26: Hypochondriasis

C. C., aged 21, had been a clerk in a downtown store since finishing high school four years before. She had never been physically strong. During infancy she had convulsions for a long time, was rather thin and anemic in appearance, round shouldered.

Despite physical handicaps, she possessed a fairly pleasant personality. She had a married sister, aged 26, who had long been thought to be queer. The parents had been dead for years. The children were raised by an aunt and uncle. Nobody seemed to enjoy this substitute setup, and as soon as possible it was dissolved by mutual consent. Since that time (about four years), C. had been living alone in a cheap apartment. She had no friends and spent most of the time, when not at work, listening to the radio and reading cheap magazines. Of late, she had specialized in physical hygiene and body culture magazines and pamphlets.

This literary diet had been dictated by extraordinary interest in her health. She heard a lecture one evening given by a heart spe-

cialist, stressing the importance of health in a successful career. Two days after the lecture she was overcome while working and practically fainted. She became pale, weak, and agitated and complained about palpitation of the heart. She said her heart had begun to palpitate rapidly and loudly. All day long she was conscious of her heartbeat. The company doctor examined her carefully and found no evidence of heart trouble. He very simply told this to Miss C., but she still continued to worry and complain about her heart condition.

In addition to this, she began to be troubled about her "malnutrition" and "hypothyroid condition." To help remedy the former, she began to eat voraciously. To improve her thyroid, she consumed foods with rich iron and iodine content as well as foods with high vitamin content.

She purchased some secondhand medical books dealing with the endocrine glands and now speaks, thinks, and reads of nothing else. Her extensive reading has led her (so she thinks) to understand more clearly to what extent she suffers from endocrine dysfunction.

She was concerned about her increasing weight. She was torn between two alternatives — she thought her increased weight might be due to defective thyroid, but realized that it might also be due to increased food consumption. She was afraid to cut down her food because of probable undernourishment. This problem occupied much of her time. In the meantime, she continued to eat and grow fat.

She was extremely unhappy over it all. When she did talk, she spoke about her health constantly. She visited and talked with all the people she knew who have had endocrine troubles.

Prognosis

The prognosis for recovery is poor because the causative conflict is usually very deeply seated and the element of gain is apparently much greater in this condition than in many other neuroses. It must always be borne in mind that the distinction between hypochondriasis and the hypochondriacal somatic delusions of schizophrenia is not always easy to make. Future observation may lead us to the opinion that hypochondriasis should not be regarded as an entity, but merely as a symptom of another disorder. When the symptomatology is bizarre and nihilistic — "my head is empty, my bowels are rotten" — schizophrenia should be borne in mind and a prognosis given accordingly.

REACTIVE DEPRESSION

Definition

A reactive depression is a disorder of psychogenic origin characterized by the development of a state of emotional depression

as a direct result of an external factor. When this factor is removed, the depression is relieved.

"Here," observes the *Statistical Guide* (002-x32), "are to be classified those cases which show depression in reaction to obvious external causes which might naturally produce sadness, such as bereavement, sickness, and financial and other worries. The reaction, of a more marked degree and of longer duration than normal sadness, may be looked upon as pathological. The deep depression, with motor and mental retardation, shown in the manic-depressive depression is not present, but these reactions may be more closely related in fact to the manic-depressive reactions than to the psychoneuroses."²²

Etiology

Grief is a normal reaction under appropriate circumstances, just as fear is normal in the presence of a threatening danger. Both emotions should soon be replaced by normal attitudes as an adjustment is made to the changed state of affairs. When grief or fear is abnormally prolonged, out of proportion to the stimulus causing this, neurosis is present. In the case of abnormally prolonged grief or disappointment, the reaction is usually one of depression. As a general rule, where the depression is directly related to an appropriate cause, the reaction is considered neurotic rather than psychotic.

Symptoms

The symptoms are the same as for those of any depression and are fully described under that heading (p. 379).

Suicide is as likely to occur in neurotic depressions as in psychotic types.

Prognosis

The outlook for recovery is good if the causative factor can be discovered and removed. As a general rule, the disease is self-limited, although its source is variable.

SUMMARY

This chapter concludes our discussion of the neuroses. Their study is important because they are widespread and consequently a cause of much suffering. It is important to realize that these conditions are not disease entities but merely symptomatic constellations. For this reason it is better to think of these disorders in descriptive rather than nosological terms.

The treatment of these disturbances will be discussed in a general way in the next chapter. More specific therapy should be sought in special texts devoted to that subject.

FOOTNOTES

1. W. S. Sadler, *Theory and Practice of Psychiatry* (St. Louis: The C. V. Mosby Co., 1936), p. 663.
2. Edward Weiss and O. S. English, *Psychosomatic Medicine* (Philadelphia: W. B. Saunders Co., 1945), p. 550.
3. Edward Strecker and E. G. Ebaugh, *Practical Clinical Psychiatry* (Philadelphia: Blakiston Co., 1940), p. 680.
4. *Statistical Guide* (002-x10) (State of New York, Dept. of Mental Hygiene), compiled by H. M. Pollock, 12 ed. (Utica, N. Y.: State Hospital Press, 1943).
5. *Ibid.* (002-x23).
6. *Ibid.* (002-x33).
7. *Ibid.* (002-x00).
8. Wendell Muncie and Adolf Meyer, *Psychobiology & Psychiatry* (St. Louis: The C. V. Mosby Co., 1939), p. 224.
9. Pierre Janet, *The Mental State of Hystericals* (New York: G. P. Putnam's Sons, 1901), p. 519.
10. Sadler, *op. cit.*, p. 549.
11. The term "neurasthenia" is retained here because of its familiarity. It has been omitted from the new terminology because it is more likely to be symptomatic of some other disorder than to be an entity in its own right. Care should be used in applying the term clinically.
12. James J. Walsh, *Psychotherapy* (New York: Appleton Co., 1913), p. 555.
13. *Statistical Guide* (002-x30).
14. Sadler, *op. cit.*, p. 655.
15. *Ibid.*, p. 650.
16. *Statistical Guide* (002-x33).
17. Strecker and Ebaugh, *op. cit.*, pp. 538-539.
18. T. V. Moore, *Dynamic Psychology* (London: J. B. Lippincott Co., 1926), p. 209.
19. V. F. Fisher, *An Introduction to Abnormal Psychiatry* (New York: The Macmillan Co., 1937), p. 175.
20. *Statistical Guide* (002-x31).
21. See footnote 12.
22. *Ibid.* (002-x32).

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GENERAL PRINCIPLES OF TREATMENT

In no other field of medicine is the personal relationship between the patient and physician more important than in psychiatry. In psychiatry, the art of medicine is most important because the personality of the physician is an essential element in the therapy. We say this with full awareness that in certain schools of psychiatry there is a tendency to minimize the importance of the personality of the therapist and to feel that he should play, at best, a passive role. This is undoubtedly true in the classical psychoanalytical procedures, but in the short therapies necessary for everyday practice, the dynamic role which the physician plays in therapy is of the utmost importance.

The immediate aim of psychotherapy is to relieve the patient of his symptoms and ultimately to free him from the disabling effects of the conflicts that have brought them about. This might be expressed by saying that the patient should be brought into emotional equilibrium with his environment. Each therapist will naturally have his own technique of procedure which has been developed as a result of his own experience and that of others. There are no hard and fast rules in psychotherapy. We would suggest the following *approach to the treatment of the psychiatric patient*:

1. *An initial interview* for the evaluation of the immediate situation as it confronts the patient.
2. *A thorough physical and neurological examination.*
3. *An explanation to the patient of the procedures* which seem indicated as a result of the preliminary examination.
4. *A personality study* of the patient as thorough as seems indicated by the patient's condition. The minuteness of this examination will naturally depend on the severity of the symptoms and the grip which the symptomatology has on the personality of the individual and may vary from a few short interviews to numerous psychotherapeutic sessions with the aim of developing insight.
5. *Interpretation* to the patient of the significance of his symptoms. Although this is put down as a separate step, it is likely that such an

interpretation will go hand in hand with the information elicited during the interviews.

6. The development in the individual of a *philosophy of life* to enable him to face the future without being disabled by conflicts.

PHYSICAL EXAMINATION

The physical examination should always be done preliminary to psychiatric study. It should be as complete as possible, covering every system. The patient should be reassured that every effort is being made to study his case. If the physical examination reveals no pathology, the patient should be so informed. The examination should not be repeated unless some definite new development occurs, because the patient may adopt the attitude, "He says there is nothing wrong with me, but he cannot be sure because he keeps checking to see." This examination may be done by the psychotherapist, but in most instances it may be more desirable to have it performed by an internist in whose organic studies the patient may have greater confidence.

PERSONALITY STUDY

One part of the personality study which may have therapeutic value is the fact that *ventilation of the symptoms or mental catharsis* is frequently helpful to the patient. He has usually had very little opportunity to discuss his problems with an impartial adviser. He may have feelings of guilt which he has been unable to aerate and the mere fact of sharing the problem with a sympathetic and potentially helpful person may relieve him of part of the burden. For this reason, it is advisable to allow the patient to tell his story in his own way and to let him take his own pace in relating his difficulties. Unless the therapist has had adequate training and is prepared to carry on depth therapy, he should be careful about attempting to elicit too much sensitive material.

An attempt should be made as the patient relates his story to correlate events which have occurred in association with his emotional upsets. (See "Psychosomatic History.") Special methods of examination are occasionally necessary to elicit unconscious material. Among these are the following:

1. Free association,
2. Hypnoanalysis,
3. Narcoanalysis,
4. Psychoanalysis.

Special Techniques of Personality Study

1. *Free association.* Frequently during a direct examination the physician reaches a point where no more information seems to be forthcoming. He may also have acquired data concerning which he desires more information. The method of free association is a time-consuming but frequently successful method of bringing to light experiences which have been forgotten. It is based on the laws of psychological association. Many memories have been repressed by the patient because of their unpleasant nature. The emotional tone associated with them is a frequent cause of mental unrest.

The technique of this procedure is relatively simple. The patient is made as comfortable as possible, frequently in a reclining position although this position is used much less now than it was in the early days of psychiatry, and is instructed to relax and close his eyes. He is told that at first the thoughts may run through his mind so quickly that it would be difficult to single out individual ideas as outstanding, but as he relaxes and learns the technique some images will become clearer than others. He is told to attempt to verbalize these thoughts as they come into his mind. No effort should be made to select them. Any interrupting thought should be mentioned. He is cautioned that should he feel sexually aroused at any time, he should comment upon it and then adopt a new line of association. The same is true if secret material enters his mind. Many patients find it very difficult at first to associate easily. Much patience is required before he can do it well. Frequently he will say that his mind is blank. It should be explained to him that this is unlikely and that there will always be some thought in his mind. It is frequently helpful under these circumstances to suggest to him some image with which he is familiar and ask him to describe it. The patient may feel that much of the information brought out as a result of free association is immaterial, but he should be encouraged to persist.

When studying the morality of this procedure, several recent pronouncements of Pope Pius XII must be considered. The first of these has already been quoted on pages 99 and 101 and commented upon. It is clear that this talk did not constitute a condemnation of psychoanalysis as such but a disapproval of amoral methods in the practical application of the method. The second pertinent discourse was delivered on April 13, 1953, to the delegates attending the Fifth

Congress of Psychotherapy and Clinical Psychology. Pertinent parts of this discussion are:

What has just been said of ill-considered initiation, for therapeutic purposes, is true also of certain forms of psychoanalysis. One should not come to regard them as the only means of relieving or of curing psychical sexual troubles. The trite principle that sexual trouble of the unconscious, like all other inhibitions of the same origin, can be suppressed only by its being brought to the level of consciousness, is not valid enough. As to the use of the psychoanalytic method in the sexual domain, our allocution of 13th September, already quoted, has already pointed out its moral limits [see p. 99]. Truth to tell, one cannot consider as lawful, *without further explanation*, the bringing to the level of *consciousness of all the imaginations, emotions and sexual experiences which lie dormant in the memory and the unconscious*, and which are thus psychically experienced. If protests arising from a sense of human and Christian dignity are heeded, who would dare to claim that this manner of treatment does not imply both present and future moral danger, since, even though the therapeutic necessity of unlimited exploration be asserted, its necessity has not been established [*italics are the authors'*].

The point about psychotherapeutic practice that we mentioned, has to do with an essential interest of the community, namely: the safeguarding of secrets which the use of psychoanalysis places in jeopardy. It is not at all denied that a fact or knowledge which is secret, and repressed in the subconscious, may provoke serious psychic conflicts. If psychoanalysis discloses the cause of this trouble, it will want, following its principle, to draw out this unconscious element completely, and make it conscious, in order to remove the obstacle. Now there are secrets which must on no account be broken, even to a doctor, even in spite of grave personal inconveniences. The secret of Confession may never be revealed. It is equally forbidden to make known the professional secret to another, even to a doctor. The same is true of other secrets. One may invoke the principle: "for a proportionately grave reason it is lawful to reveal a secret to a prudent man and one capable of keeping a secret." This principle is correct, within narrow limits, for certain kinds of secrets. It is not right to make use of it *indiscriminately* in psychoanalytic practice [*italics are the authors'*].

From the moral standpoint, and first and foremost for the common good, the principle of discretion in the use of psychoanalysis cannot be sufficiently stressed. Obviously, it is not primarily a question of the

discretion of the psychoanalyst, but of that of the patient, who frequently has no right whatever to give away his secrets.¹

In these two allocutions it seems clear that:

1. There is no condemnation of psychoanalysis as a whole.
2. There is disapproval only of "the pansexual method of a certain school of psychoanalysis."
3. "Certain forms" of psychoanalysis are not to be regarded as the only means of a cure of psychic ills.
4. Unless some "further explanation" is offered, it cannot be considered lawful to reactivate all sexual imaginations, emotions, and experiences.
5. Psychoanalysis may jeopardize the keeping of secrets.
6. Secrets may not be revealed indiscriminately in psychoanalytic practice.

These statements are sufficiently clear and need no comment except that concerning the reactivation of sexual imaginations, emotions, and experiences. This it would seem refers to a phenomenon known as "abreaction." Abreaction means a re-experiencing, a reliving of a previous experience which because of psychic inhibition has been repressed. It may be touched off under appropriate circumstances by a chance word, a thought, an experience. Father Snoeck defined abreaction thus:

It is a discharge of blocked emotions, a discharge apparently caused by the recall to memory and the relived experience of a personal situation in the past that has been traumatic for the subject.²

Abreaction may occur in any emotional area, not merely in regard to sexual experiences. It may occur spontaneously or under the urging of the therapist. It is clear from the definition that sexual abreaction may lead the patient into a proximate occasion of sin. Father Snoeck in the article referenced above gives an excellent description of the morality of psychiatric abreaction. It was written before either of the allocutions quoted above. This is also true of the discussion of Nuttin³ and of VanderVeldt and Odenwald. The latter authors commented on abreaction as follows:

The aim of the cathartic method, with or without hypnosis, is "abreaction." The reproduction into full consciousness of memories, representations, and emotional experiences makes the patient face them as they are. . . . He is made to reactivate and actually relive the psycho-

traumatic events of past life that were forgotten, suppressed, and not completely digested. Lived through again, the original experiences become "abreacted" together with the emotional component that caused the neurotic state.⁴

We are not sure that we can agree with this viewpoint. Abreaction is not the primary aim of the cathartic method, not at least if abreaction means a "reliving," "a repetition of a former experience." The cathartic treatment consists in a conscious recall of a previous emotionally toned situation or experience not necessarily a "carrying out" or "acting out" of this situation. The reason for this recall is that the experience which had previously been repressed through fear can be recalled and then rationally and consciously rejected. The repressed conflict remains dynamic and likely to be productive of symptoms until it is thus reactivated and allowed to "die a natural death." The question of the sinfulness of such recall is raised by the statement of the Holy Father. Certainly no psychiatrist would suggest the deliberate reactivation of previous sexual experiences for therapeutic purposes. We would certainly have to reject any form of treatment which would deliberately lead to immoral practices, or lead an individual into the proximate occasion of sin. Formal sin must be excluded from any form of treatment. This might certainly be a danger when abreaction of certain types of situations was deliberately invoked. Where the abreaction occurs spontaneously the situation is different.

In this regard Father John R. Connery, S.J., commented as follows:

Even if the treatment did involve material sin, then, I do not see how the patient could foresee this eventuality. Let us suppose now that the process of free association brings this sinful desire or experience back to consciousness. What is required for the therapeutic effect of the analysis?

If the actual execution of the sinful desire or repetition of the sinful experience were necessary, the analyst would not be justified in encouraging it or promoting it, even though the present state of the patient might make it only a material sin. But I doubt that reputable psychoanalysts today would maintain the need for such expression. Everyone will admit that sexual expression relieves sexual desire, but everyone knows as well that yielding to the sex appetite also strengthens it. So I doubt that sexual expression would, or even could, be considered a genuine therapy in these cases.⁵

It does not seem that spontaneous abreaction involves any degree of

deliberativeness. In the nature of the process of free association the patient is lost in reverie, by a process of association he is attempting to recall events and emotions which are lost to his conscious memory. In the course of this procedure, in which his detachment may be so great that when he stops it may seem like an awakening from sleep, he spontaneously comes upon a chance word, a memory, or an emotion which brings about the expression of a feeling which he has previously experienced. Most of these emotions were experienced in early life. They are reactions of the infantile ego not those of the present adult ego. Such repressions when they are recalled are not often, if ever, the subject of sinful desires or temptations. The expression of emotion does not necessarily involve pleasure. It is more likely to be associated with feelings of guilt or shame. Hostile feelings which are ventilated are the result of past relationships rather than those occurring in the present. They do not, therefore, have reference to any current attitudes. Such abreaction may lead to materially sinful acts but such reactions are on the margin of the therapy and are neither an end nor a means to the result which we seek. The end sought is the psychic integration of the patient. For this purpose the expression of feelings is necessary but such release does not necessarily involve a reliving of such an experience.

There are some who feel that the Pontiff's comments refer to the use of free association as well as to psychiatric abreaction. With these I (J.R.C.) do not agree. It is, of course, true that abreaction may occur during, and as a result of, free association. While we do not practice psychoanalysis we employ free association. The use of this technic is not one confined exclusively to psychoanalysis but may be used by any psychiatrist. Abreaction may occur at any time in psychotherapy but this occurs spontaneously and is infrequent.

If, while free associating, the patient becomes aware of an increasing sexual tension or of secret material which should not be revealed, he can easily comment on this fact and either spontaneously or at the suggestion of the therapist start a new train of associations. No great harm is done to the value of the associations if they are thus occasionally interrupted by the patient. In many years of practice we can recall no occasion on which secret material was improperly confided. Although it is possible, as pointed out by the Holy Father, for secrets to be a source of conflict, this is not a very frequent occurrence.

Free association, which used to be considered a basic technic in psychoanalysis, is no longer regarded as the *sine qua non* of intensive

psychotherapy as it once was. More direct methods are being employed. In this, psychoanalysts such as Fromm-Reichmann agree with the Pope.

To repeat: free associations used to be a most helpful device for gaining access to patients' repressed and dissociated thoughts and feelings and to doctors' and patients' understanding of the meaning of their contents. At present they are less useful, however. To many of us uncovering the dynamics motivating these repressions and dissociations and investigating patients' security operations can be better accomplished, as a rule, by skillfully eliciting and listening alertly to the patient's directed and informative statements than by encouraging his free associations.⁶

It seems likely that taking into account the opinion of the Holy Father, as expressed above, free association, with the possibility of abreaction, is morally acceptable under the following circumstances:

1. There is a sufficiently grave reason for using it.
2. Formal sin is to be avoided at all costs.
3. Material sin is also to be avoided as far as possible.
4. Deliberate reactivation of sexually stimulating situations would be illicit.
5. Where possible, indirect means of approach to the problem should be adopted.

2. *Hypnoanalysis*. Hypnoanalysis is becoming recognized as a useful procedure in personality inventory. As it is at present employed, it is advocated as a short psychoanalytic technique. Linder, who is an enthusiastic proponent of the method, states, "Through the use of hypnoanalysis the period of treatment for most, if not all, psychopathological conditions can be shortened effectively without loss to the patient, for the cathartic and abreactive processes are just as complete and the therapeutic yield as rich as that claimed for any other given psychotherapeutic tool. In this respect, the method may be viewed as an heroic one, assaulting the organism somewhat in the manner of metrazol or electric-shock therapy, literally tearing aside the veil."⁷

The patient is hypnotized and asked to recall his past experiences. In suitable subjects it is timesaving because the hypnotic regression is such that the patient seems to relive his past experiences, and the suggestions produce memory recall with great vividness.

It has the further advantage that marginal material can be recalled

more rapidly, since its revelation is without the conscious knowledge of the patient.

3. *Narcoanalysis*. World War II gave a great impetus to the use of various drugs in the study of personality disorders. The drugs most commonly used were sodium pentothal and sodium amytal. Sodium pentothal is preferred because it has a less depressing effect and is more quickly metabolized in the body and, therefore, is more quickly excreted. These drugs have been referred to as "truth serums." This designation is far from accurate. They are useful in lowering the patient's inhibitory level, if he finds it difficult to talk about some painful conflict. It may uncover certain repressed conflicts, if these are merely kept out of consciousness because of their painful nature. If, however, the individual deliberately intends to conceal certain facts, he is quite unlikely to reveal them under the influence of the drug, at least when direct questions are asked. Confusion induced by the drugs may, with proper suggestions, result in statements concerning concealed matters which might be helpful in leading to the truth. These drugs are of greatest value in cases of hysterical amnesia. In such cases, it may bring back a rapid return of the memory. In the administration of these drugs for this purpose, a 2½ per cent solution is given intravenously. The drug is administered at a rate rapid enough to produce a somnolent state. When this state is achieved, the patient is encouraged to talk. It is more effective if the patient has been interviewed previously in order to discover some of the more emotionally significant areas in which questioning as therapy may be desirable. These matters are then brought up to him in his somnolent state and he is encouraged to discuss them.

The method has very little value in civilian psychiatry. It had tremendous value in military psychiatry. In the severe psychic trauma induced by combat situations, the patient was frequently immobilized by his fear. In these cases, the use of the drugs enabled him to release his pent-up emotions with marked therapeutic effect.

In regard to the morality of this procedure, we would like to quote the following paragraph from *Ethical and Religious Directives for Catholic Hospitals* (p. 7): "The use of narcosis (or hypnosis) for the cure of mental illness is permissible with the consent, at least reasonably presumed, of the patient, provided due precautions are taken to protect the patient and the hospital from harmful effects, and provided the patient's right to secrecy is duly safeguarded."⁸

A similar opinion has been expressed by Father Francis J. Connell, C.Ss.R., and a French priest-psychiatrist, Father J. Geraud.

4. *Psychoanalysis*. A great deal has been said and will be said in this text concerning Freudian psychoanalysis. Alexander defines psychoanalysis in these terms:

Psychoanalysis, in common usage, is both a practice and a theory; it is concerned with techniques and with principles. From the microscopic study of many individuals under psychoanalytic treatment, a theory of personality development has been devised—a theory which, as in every science, is constantly changing with new discoveries. These principles of the dynamics of personality have wide application. They are not limited to the practice of psychoanalysis, nor yet to the wider field of psychotherapy in general. They extend to many fields, to every sphere of activity in which the human being is an object of study.⁹

As a means of therapy, it aims at the redistribution of psychic energy and goes much further in its scope than the usual personality study. It aims at eliciting unconscious conflicts and interpreting these to the patient. The method of psychoanalysis includes the use of free association, dream interpretation, and the manipulation of the transference phenomenon. As a general rule, the therapist remains passive throughout the therapy and interprets the findings at appropriate intervals.

By "transference" Freud meant reaction to the analyst as though he were not himself but some other person in the patient's past. According to this definition, a patient's transference to the analyst is only that part of the patient's reaction to the analyst which repeats the patient's reactions to a person who has at some previous time played an important role in the patient's life.¹⁰

RESYNTHESIS OF THE PERSONALITY

As a preliminary to an attempt to re-educate the patient along lines of better mental hygiene, it is frequently desirable, once the personality inventory is completed, to review the case briefly with him, pointing out the relation of stress to symptoms and to the faulty mental mechanisms involved. The first step in re-education is to be sure that that patient accepts the psychogenic origin of the symptoms. Until this is done, nothing can be accomplished, and before any attempt at further re-education is made, the therapist should delay at this point. Frequently, the mental catharsis involved in the personality inventory

relieves the patient of part of his emotional stress. In many instances, the patient will, himself, recognize the etiological factor in the background which has produced his symptoms.

CASE 27: *Symptomatic Relief From Catharsis*

Mrs. B. S., 23 years of age, sought psychiatric advice because she developed feelings of apprehension upon the discovery that alcohol was markedly effective in relieving feelings of tension. She had not overindulged and could not in any way be considered an alcoholic. In the course of her history she stated, "I've noticed lately that the pain in my head comes as a result of impatience. I am never late for an appointment and my friends always are. I noticed that today, and I got a headache when I had to wait. I never stood group instruction very well. I was never allowed to go to high school dances. I knew this was for the best, but Friday nights were very lonesome. I was always close to my mother. Father was not very socially minded. We lived out in the country on a large estate and it was hard to get to town. I became more lonesome as I grew older. I stayed there until six months before I was married. Father was always a source of fear to me. He frightened me several times. He is now more like I wish he had been all of the time. My nightmares and fear of the dark started when we moved to Virginia at which time I was nine years old. The place was very lonesome. Daddy would get drunk and threaten our lives. I really believed that he would kill us. He hasn't done this since we were married, but he did it about two months before. I promised myself that if it ever happened again, I would leave home (with this she burst into tears). I've never told anyone else about this." At this point, the patient appeared startled and stopped talking for a moment and then said, "That must be the reason I've always been afraid of drinking. I saw what it did to father and how miserable it made mother's life and mine."

The method employed in the re-education of the individual will depend on the information elicited in the personality inventory. As has been pointed out, this will usually deal with the development of more mature attitudes and the elimination of faulty methods of thinking. An authoritative attitude should never be adopted. The patient must not be treated as a child. His problems should be discussed at an adult level.

Since each case must be individualized, no specific directions can be given. It is extremely important that the patient be taught proper mental hygiene and that the nature of his symptoms, the method of

their production and how they have influenced his development, be explained to him. According to his ability to digest the material, much of the information contained in the preceding chapters on habit formation, mental mechanisms, the genesis of psychic disorders, and other pertinent material should be thoroughly explained.

The development of insight in the patient of the psychogenic nature of his complaints may be, in many instances, equivalent to a cure. Attempts to argue with him are useless. He must be guided so that he himself will recognize the nature of his trouble.

SPECIAL THERAPEUTIC PROCEDURES

1. *Suggestion*. In spite of the fact that the cure must come from within the patient, it must be recognized that all forms of treatment contain some element of suggestion. When a physician gives a patient a prescription for a drug and states, "This will fix you up," he is practicing suggestion in much the same way as was Coué when he said, "Every day in every way I am getting better and better." As much as possible, suggestion should be avoided because it offers little hope of a permanent cure.

2. *Hypnotism*. One form of suggestion which has been widely discussed in recent years is *hypnotism*. This useful therapeutic measure has unfortunately been so tainted with quackery and mysticism that many patients are reluctant to consent to its use. It should be emphasized that, in proper hands and for the proper patient, it may be an excellent therapeutic measure. Hypnoanalysis and hypnosynthesis are both being employed with increasing success. Little is known of the mechanisms involved in the production of the hypnotic state. There is, however, nothing mysterious nor occult about the process. The hypnotist needs no special power and the patient is not harmed by the process. Almost anyone can induce the hypnotic state and anyone who is willing can be hypnotized. No one can be hypnotized against his will.

There are numerous methods of producing the hypnotic state. Most of these call for the fixation of the eyes on some bright object. The simplest procedure is to hold a bright light in front of the patient's eyes, close enough, and slightly above the level of the eyes, so as to cause upward and internal rotation. He is instructed to stare into the light and at the same time attempt to eliminate any distracting thoughts from his mind, concentrating on the thought of sleep. The hypnotist then speaks in a

low, monotonous voice suggesting to him that he is becoming relaxed and that his eyes are closing and he will soon be able to respond only to the suggestions of his voice. In suitable subjects the hypnotic state can usually be induced rather quickly. The speed of the induction depends to a large extent on the method employed and the skill of the hypnotist. The mental state produced by hypnotism, although not fully understood, is very similar to that in hysteria and while under its influence the patient is very suggestible. It is because of this increased suggestibility that the method has therapeutic value. A suggestion made to the patient in a hypnotic state will usually be carried out when he is restored to his normal condition. This is known as posthypnotic suggestion. For example, a patient with a severe pruritus vulvae of hysterical origin was hypnotized and told that the symptoms would disappear the next time she took a bath. Although the patient did not remember this suggestion when she was awakened, she reported the next day that her symptoms had disappeared the previous night while she was taking a bath and had not returned. Another patient with a severe phobia of impending death was hypnotized and it was suggested to her that this feeling would have disappeared completely when she was awakened. Upon being aroused from her hypnotic state, she not only forgot about her symptoms, but expressed some wonderment as to exactly why she had come to see the physician. This symptom did not recur.

There are certain misconceptions in regard to the hypnotic state which are prevalent even among members of the medical profession. It should be understood that no one can be made to do anything under the influence of hypnotism which would actually be repugnant to him if he were not hypnotized. For example, no one could be made to steal or perform indecent acts if he did not at least have a repressed desire to do these things. No one who is under the influence of hypnotism can be made to remember things which he has never known. The not infrequent reports that people under the influence of hypnotism have been able to locate objects concerning which they have no previous knowledge cannot be true. The senses can be remarkably increased in acuteness. The following experiment is not unusual. The subject is hypnotized and told that he has a very acute sense of smell. He is taken from the room and those present are asked to place some object on the table. On the subject's return to the room, he smells the hands of each person present and then is told to return each object to its proper owner

through the sense of smell. He is usually able to do this without difficulty.

Hypnotism does not weaken the will, and debility of character has nothing to do with its induction. The hypnotist need not have a stronger will than the subject. It is true that less effort is required to induce the state after the first successful attempt. This seems, however, to be due to a better understanding on the part of the patient of what is required and a reduction of his resistance to being hypnotized. The skill of the physician must be the guide to the length of the hypnotic sessions. Hypnotism should not be employed by the unskilled. It should be employed only by a skilled physician for a proper purpose. It has previously been taught that it should be done only in the presence of a witness. We are, however, in accord with the opinion expressed by Kelly in regard to the necessity of having witnesses:

Also, it seems to me, the condition concerning the need of a trustworthy witness needs interpretation. In some psychiatric interviews the material might be of such an intimate nature that the patient himself would not want to communicate it to a witness. Moreover, though this necessity of a witness is generally emphasized by theologians in their discussion of hypnotism, I am of the opinion that today, in this clinic and record age of ours, there is greater need of stressing the patient's right to privacy. Hence, I am of the opinion that we cannot put this need of a witness down as an absolute condition. Much will depend on circumstances. In some cases, for instance, a witness might be necessary to safeguard the reputation of the doctor or the hospital. But, granted that the physician is known to be conscientious—and the presumption is that only such physicians are allowed to practice in Catholic hospitals—I see no special need of a witness to safeguard the patient.¹¹

3. *Teaching the patient how to play.* Most people do not know how to make the most of their leisure time. They carry their troubles with them constantly. For such people, a hobby would be of great value. Almost anything in which they are sufficiently interested can be converted into an inexpensive distraction which serves very effectively as a release for pent-up emotions. For many, gradually increasing physical exercise may produce sufficient muscular exhaustion to bring about restful sleep. It is always a mistake to indiscriminately advise vacations away from home, and such advice should be given only after a thorough personality inventory.

4. *Exercise therapy.* Another important adjuvant to treatment in psychiatric disorders is exercise therapy, more commonly referred to as physical training. Psychiatric physical training may be more appropriately thought of as exercise therapy. For the mental patient, this includes all nonmedical muscular manipulation consciously applied to the treatment of the individual. Activities may be classified as games, contests, calisthenics, and its derivatives, track and field, aquatics, gymnastics, running and hiking, and testing. Each of these categories is broad in scope varying from unorganized, simple, automatic practices to those of a complex, highly organized nature. The form and extent of exercise is indicated by the needs of the patient. Also of importance are the interests of the individual under treatment.

Values, derived to varying degrees, from participation in exercise therapy are:

- a) Maintenance or improvement of general physical condition;
- b) Socialization;
- c) Recreational diversion; and
- d) Release of tension and its concomitants.

Even a superficial survey of mental and personality disorders indicates the universal utility of exercise therapy as an adjunct in psychiatric treatment. Tension is pronounced in neurotic and psychotic individuals as is the trend toward a socialization and physical decadence, and the need for recreational diversion is accentuated among introspective individuals confined to the limits of the hospital ward.

Exercise should always be prescribed by the physician and is best executed under the leadership of a psychiatrically trained physical instructor. Periodically, the instructor should submit to the physician a thorough report of the patient's progress in physical activity. All psychomotor activity of the patient should be under constant surveillance during exercise. Observations should be recorded and submitted for use in diagnosis, treatment, progress evaluation, and determining eventual disposition of the patient.

5. *Physical status of the patient.* The physical well-being of the patient should never be neglected. Psychoneurotic and particularly psychotic patients are frequently malnourished and suffer from insomnia.

Because of the tendency of many psychiatric patients to disturbances which affect their intake of food, special attention should be paid to their dietary habits. An effective method of estimating the food intake is a weekly check on the weight of the patient. For those

who have gained or lost excessively, special observation may be instituted. A frequent food disturbance in psychotic patients is a craving for unnatural articles of food (pica). Many psychotic patients have a tendency to swallow foreign bodies and X-ray examination will frequently reveal the presence in the gastrointestinal tract of a variety of objects, such as knives, forks, and nails. In the presence of a poor appetite, special attention should be paid to the patient's desires and the food should be served in as an attractive manner as possible.

Undoubtedly, vitamin therapy has been overstressed and commercialized. Special care should be given, however, to this subject in patients who have, as a result of their condition, placed themselves on restricted diets. In alcoholic patients, particularly, Vitamin B deficiencies are likely to occur because of the restricted consumption of food during the period of overindulgence. Pellagra is characterized in its later stages by psychotic manifestations. The administration of nicotinic acid (100 to 500 mg. daily by mouth) may be curative of this condition.

For those patients who refuse to eat, *tube feeding* may be necessary. As a rule, this is easily accomplished by passing a Levine tube through one of the nostrils and the food is allowed to run in by gravity. Where prolonged tube feeding is necessary, special attention should be paid to the vitamin needs of the individual. The following formula contains all of the essential food elements and is adequate for a single feeding:

Milk	1½ pints	Tomato juice	½ cup
Eggs	2	Salad oil	2 tbsp.
Sugar	3 tbsp.		

The *ketogenic diet* has proved of value in the control of epileptic disorders, but because of the difficulty of maintaining the patient on a 3¼ to 1 ration for an adequate length of time (ideally, about three years), it has been largely displaced by chemotherapy. In some hands it was estimated that the ketogenic diet gave at least a seven-year (period of observation) cure in 91 per cent of the cases.

6. *Drug Therapy.* Since the recent introduction of the so-called "tranquilizers," the number of these drugs used has been phenomenal. It is reported, for example, that 35,000,000 prescriptions were written in 1956 alone. The term "ataractic" is now coming into popular use to designate these drugs, in place of "tranquilizers." This term was sug-

gested by Alister Cameron, professor of Classics, University of Cincinnati. He suggested "ataractic," a word of Greek derivation, meaning "freedom from confusion," "peace of mind."

As an authoritative opinion we would like to present Dr. Wortis' summary of the effects of these drugs:

1. Serious complications occur in from 5-10% of patients treated depending on the dose.
2. [It is] an effective sedative . . . although it is not equally effective in all cases.
3. [These drugs] reduce anxiety and drive and exert a calming effect on psychomotor excitement.
4. Its calming effect . . . may sometimes overshoot the mark and depressive reactions or exacerbations are by no means uncommon when the drug (reserpine) is used.¹²

These comments probably express the carefully considered opinion of most psychiatrists. There is not one word here about cures, nothing spectacular, not a word about miracles. These drugs do not cure. Wortis in the same article continues:

[These drugs] are especially useful in the relief of psychotic excitement, autonomic agitation, anxiety, or related dysfunctions, but are contraindicated in most cases of apathetic or akinetic depression, and in neurasthenic or obsessive states.¹³

Relief of symptoms is all that is to be expected. There is a real danger that these drugs could become the "aspirin" of psychiatry. If used indiscriminately, they may by masking symptoms conceal a more serious disorder.

Do not misunderstand. These drugs have real value. There is no doubt that certain beneficial results come from their use, e.g.:

- a) They give symptomatic relief in many cases.
- b) They may arrest the evolution of an acute psychosis.
- c) They may modify the progress of a chronic psychosis.
- d) They may make the patient more amenable to other treatments especially psychotherapy.

Much valuable experimentation with these drugs has been done. This is the first step. Now we need the test of time. This alone will tell the whole story. No one would be happier than the authors if the predictions of the most enthusiastic workers were verified.

The original tranquilizer was a Rauwolfia-alkaloid (reserpine),

best known by the trade name Serpasil. Although this was effective, it soon became apparent that many cases of depression occurred as a result of its administration. It was, however, of value in cases of tension, excitement, inner unrest, and schizophrenia. Its depressing action led to many distressing results. The second drug in order of use was chlorpromazine (thorazine). This is probably the one most extensively used today. This drug has three fundamental clinical properties:

- a) Its profound antiemetic effect,
- b) Its ability to potentiate anesthetics, narcotics, and sedatives, and, most important of all,
- c) Its capacity to alleviate anxiety, tension, and agitation — without dulling mental acuity.

The last quality is that which makes chlorpromazine useful in the treatment of mental and emotional disorders. It also makes it of value in the treatment of various psychomatic disturbances in which emotional stress is a complicating or etiologic factor.

The outstanding property of this drug is its ability to relieve tension, reduce anxiety, quiet agitation, reduce confusion and apprehension. It is said to produce a unique tranquilizing effect — “a detached serenity without clouding of consciousness or depression of mental faculties.” To a large degree it lives up to these claims. It also, like Serpasil, may produce or aggravate depressions.

After Serpasil and thorazine, many other similar drugs were placed on the market. Among the better known of these are promazine (sparine), meprobamate (Miltown), Equanil, Trilafon (perphenazine), Frenquel (azacyclonal), and Pacatal. There are many others which vary slightly one from the other but all belong in the group of drugs now known as “ataractics.”

Since we do not feel that the average reader of this book expects to gain expertness in the use of these drugs by reference to this text, the details of dosage and usage will not be given here. Suffice it to say that they are useful adjuvants in the treatment of a variety of mental and emotional disorders. They are not, to the best of our present knowledge, in any sense curative.

7. *Bibliotherapy*. Bibliotherapy is an aid to psychotherapy through reading. There is nothing new in this concept. For centuries reading has been a means of altering attitudes and developing new ones. The written word has changed the fate of nations and seriously altered the futures of individuals. Solace has been found in books. New ideas

and correction of old ideas have brought both discomfort and peace of soul. The value of bibliotherapy has been overlooked by many psychotherapists. Not many serious attempts have been made to explain its possibilities. A comprehensive bibliography of the literature on this subject was given by J. M. Schneck.¹⁴

Various analyses have been made of how bibliotherapy works. These studies may be summarized as follows:

a) Better understanding of his psychological realms is produced in the patient.

b) The terms used in psychotherapy and their meaning may be helpful.

c) By providing better understanding, it may help the patient to realize his problems and to understand that others have the same difficulties.

d) Better understanding of the problem may help the subject make better plans for his future.

e) It may, by making the individual aware of his immaturity, promote better patterns of behavior.

f) It may enlarge the individual's sphere of interest, promote new patterns of behavior, and stimulate his imagination.

g) Certain types of literature may promote "peace of soul" by making the individual more aware of spiritual and religious values.

Techniques in this method of therapy and selected readings are not well studied and no suggestions will be offered here. Those prescribing such therapy should carefully read the books which they recommend. It is dangerous to recommend certain books, even though written by well-known churchmen, unless one is familiar with their content. The prescription cannot be a general one, but must be for this *particular* patient.

8. *Information from the family.* Information from other members of the family, especially those in intimate contact with the patient, is frequently of great value and should be obtained whenever possible. The patient's consent should always be obtained before discussing his condition with any member of the family and confidences of the patient should not be divulged without his consent.

AIM OF THERAPY SHOULD BE TRUE SELF-RE-EDUCATION

The goal of treatment for the patient should be true self-re-education, the rational and spiritual approach to his conflicts. He should be helped to develop a true philosophy of life. This should

be developed in accordance with his ability to assimilate it. An effort should be made to clarify for the patient his goal in life and how it may be best attained. He should be encouraged to accept worth-while principles and make them operative in his daily life.

There is a tendency on the part of many therapists to reject the intellectual approach in psychotherapy. However, in many cases a purely intellectual procedure may be very effective. In a recent article Dubois makes this comment:

Most patients are intelligent and early demonstrate partial insight. . . . The patient's general maladjustment is considered, and efforts are directed towards total personality improvement. This includes discussions of maturity and immaturity, the hedonistic principles of conduct and the necessity of establishing purposes and goals in life. Without exception it has been necessary to help the patient plan for the future and evolve a setting for living . . . that will in due time bring independence and a sense of belonging.¹⁵

THE INTELLECTUAL APPROACH IN THERAPEUTICS

An intellectual approach is a method in harmony with man's nature. It implies first and above all self-activity on the part of a patient who, because of conflicts and frustrations, has escaped into a neurotic illness. The intellectual approach to therapy injects new life and vigor into the patient by inciting him to assume progressively increasing responsibility for his own improvement. Such an approach to his problems helps him to clarify his hazy perspective and encourages him to seek satisfaction in reality.

The following quotation from Dubois seems pertinent here: "Another Frenchman, Daquin (*Philosophie de la Folie*, 1791), had written the memorable sentence: 'Greeted as paradox though it will be, I nevertheless maintain that for the cure of those who have lost their reason, there is no other means than to make them . . . reason.'"¹⁶

For complete psychic therapy, however, it is essential that reason be supplemented by the message conveyed through revelation as to man, his nature, and his destiny. No contradiction will be found to exist between philosophy and revelation. The latter will elevate reason and make its methods more secure.

FOOTNOTES

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3. Joseph Nuttin, *Psychoanalysis and Personality*, translated by George Lamb (New York: Sheed and Ward, 1953), pp. 148-155.
4. James H. VanderVeldt, O.F.M., and Robert P. Odenwald, M.D., *Psychiatry and Catholicism* (New York: McGraw-Hill Book Co., Inc., 1952).
5. John R. Connery, S.J., "Notes on Moral Theology," *Theological Studies*, Vol. 17, No. 4, December, 1956.
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9. Franz Alexander and Thomas M. French, *Psychoanalytic Therapy* (New York: Ronald Press Co., 1946), p. 4.
10. *Ibid.*, p. 71.
11. Kelly, *op. cit.*, p. 15.
12. Joseph Wortis, "Physiological Treatment," *American Journal of Psychiatry*, 112:7, January, 1957, pp. 526-529.
13. *Ibid.*
14. J. M. Schneek, "A Bibliography of Bibliotherapy and Hospital Libraries," *Bulletin of the Medical Library Association*, 33:3, July, 1945.
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16. Paul Dubois, *The Psychological Origin of Mental Disorders* (New York: Funk & Wagnalls Co., 1913). Authorized translation by Edw. G. Richards (Edinburgh), p. 16.

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PART V

THE PSYCHOSES

CHAPTER

XIX. DEFINITION AND CLASSIFICATION OF THE PSYCHOSES

XX. THE SCHIZOPHRENIAS (DEMENTIA PRAECOX)

XXI. THE MANIC-DEPRESSIVE PSYCHOSES

XXII. INVOLUTIONAL MELANCHOLIA: AGITATED DEPRESSION

XXIII. PURE PARANOIA AND PARANOID STATES

XXIV. TOXIC PSYCHOSES

XXV. SOMATOPSYCHIC DISORDERS

DEFINITION AND CLASSIFICATION OF THE PSYCHOSES

Psychiatric study deals with mental and emotional disorders, i.e., those states of mind which deviate to a more or less noticeable extent from the normal. It is more proper to designate such states as disorders of the mind than to speak of them as mental diseases. Disease always implies some pathology of the body or organism, some biological alteration of the state of the human body. It is correct, therefore, to refer to diseases of the body, but it would seem to be incorrect for this reason to refer to diseases of the mind. At best, such language is figurative, but due to a particular circumstance such a figure of speech is dangerous. The "circumstance" referred to is the prevalence of the materialistic concept of mental disorder. The "danger" referred to is the error of considering the mind as an organic, bodily entity indistinguishable from the gray matter or brain.

If the mind were actually identified with the biological brain, if the processes of thought and volition were secretions of the gray matter, then it would perhaps be permissible to call mental disorders mental diseases and to mean it literally. Such, however, is not the case. The brain is indeed a necessary condition of mental life, but it is by no means the mind. The problem of clarifying and substantiating this statement belongs in the province of elementary psychology which is here presumed.

DIVISION OF MENTAL DISORDERS

The subject matter of psychiatry is quite diversified, as will be seen by reference to the classification at the end of the chapter. Its two principal subdivisions are (*a*) the psychoneuroses and (*b*) the psychoses. The neuroses have been discussed in detail in previous chapters. In this chapter, we try to define and explain the psychoses.

DEFINITION OF A PSYCHOSIS

In attempting to arrive at a satisfactory definition of a psychosis one is inclined to agree with Lord Blackburn, who wrote more than fifty years ago, "I have read every definition (of insanity) which I

could meet with and never was satisfied with one of them, and I have endeavored in vain to make one satisfactory to myself. I verily believe it is not in human power to do it."¹

Many authors have attempted such a definition.

Hinsie and Shatzky define a psychosis as:

In current psychiatry, a mental disorder of a more or less special kind, which may or may not be associated with an organic disease. . . . A psychosis is usually a severer type of mental disorder in the sense that all forms of adaptation (for example, social, intellectual, professional, religious, etc.) are disrupted. In other words, the disorganization of the personality of the individual is extensive.²

Davidson defines a psychosis as:

In operation, the same as insanity; theoretically, a severe mental disturbance of any sort. Insanity is a legal term indicating some kind of mental incapacity. In practice, however, to call a man psychotic is to call him insane, and various forms of insanity such as dementia praecox, melancholia, etc., are all psychoses. Judges occasionally "split the hair" and say that a certain patient has a psychosis, but that he is not insane. This is what the court does when it orders a release from the hospital of a patient who is admittedly psychotic. The judge in theory says that while the patient has a psychosis, he is not insane. But as a practical matter, what the court really means is that the psychosis (insanity) is not of such degree as to require confinement. The true distinction is between certifiable and non-certifiable insanity, rather than between insanity and psychosis.³

The *Technical Manual* gives this definition:

A psychosis, excluding those of organic origin, is the pathological resultant of a conflict exhibiting itself in social behavior. From the standpoint of disordered mental functioning, it is the expression on the part of the individual of his type of reaction to the conditions of his environment.⁴

Billings, following Meyer, states:

The major reactions or major psychoses, or merely the psychoses, are characterized as being disorders of the whole mentally integrated person. That is, they are sweeping reactions that in general so derange the socially organized personality so as to interfere with self-conduct to the obvious detriment and hazard of the patient and of others, and to the extent of requiring treatment and care, even against the patient's

will. These reactions, just as in the case of the minor reactions, may be transitory or lasting, stationary or progressive, and structurally or functionally determined. The major reactions in general do not involve the personality merely as major degrees of development deficiency or of psychopathological instability.⁵

Skottowe has this to offer:

When the changes in thought and feeling or in the sensorial or intellectual functions become intense and pervade all the aspects of mental activity more or less extensively the patient's sense of values becomes seriously altered, compared with that of his fellow men. He no longer sees the external world in the same terms as they do, and although he may or may not realize that something strange is happening to him, he no longer "talks the same language" as mentally healthy people. Mental illness of this degree arising in a previously healthy individual is known as a psychosis.⁶

Noyes and Hayden define a psychosis as "A major form of mental disorder resulting in considerable disturbance of personality."⁷

With these definitions in mind we offer the following definition: *Psychoses are either temporary or prolonged grave deviations from normalcy in judging, reasoning, and willing which are the result of the individual's failure to adequately solve his conflicts and which may result in disturbed or inappropriate emotions, delusions, seriously irregular conduct, and deep-seated personality disorganization, and other symptoms.*

Explanation of the Definition

1. Psychoses are grave deviations from normalcy.

Men are alike in that they possess: (a) a common nature composed of body and soul; and (b) a common goal.

Basically all men have a similar power to judge, reason, and will. A natural law promulgates to men their basic, essential relations and duties. The human race as a unit follows a consistent pattern both in its intellectual, emotional, and volitional activities, as well as in its external behavior. Hence, the normal man is spoken of as the individual whose conduct and behavior follows a definite rule or accepted standard. The norm or standard of conduct is the recognized harmony between an action and man's nature, and the suitability of the action to lead toward the goal of rational endeavor.

Man's nature is, however, constant and so also is his goal. A specific mode of conduct, therefore, becomes man and is normal for him

and is expected of him. Men, therefore, speak of normal, proper, becoming, rational behavior. Such behavior is recognized almost instinctively.

When, therefore, the behavior of an individual is gravely at variance with what becomes man's nature and goal, it is considered either as the expression of a vicious character or as symptomatic of intellectual derangement.

In the latter case, it is recognized that the individual has lost his hold on the correct sense of values and is becoming deluded. Hence, the definition of psychoses contains the words "grave deviations from normalcy in ways of thinking, judging, and willing."

2. *Psychoses are either "temporary or prolonged . . . deviations from normalcy."*

The "grave deviations" referred to are either (a) temporary or (b) prolonged.

a) *Temporary grave deviations from normalcy.* Man possesses an intellect which begets ideas, judges, and reasons. He also enjoys free will which, among its other functions, elicits the act of choice. The will depends on the activity of the intellect as upon a necessary condition for its own activity. Man's rational choice, the act for which he is accountable, presumes the adequate stimulation of the external senses, the integrated co-ordinated activity of his internal senses, and the subordination of instincts, impulses, and emotions to reason. The temporary uncontrolled exercise of such psychic processes as anger, hatred, jealousy, desire, rejected love, fear, despair, and dozens of such impulses and emotions may for a brief span totally upset reason, beget delusions, and result in psychoses. Such condition is known as temporary insanity.

Temporary insanity. Those whose early defective character formation did not instill in them adequate habits of self-control may become temporarily deranged mentally. With the cessation of the overpowering emotions, however, they regain their full use of intelligence.

Those with delirium tremens and acute alcoholic hallucinosis and certain psychopaths are also evident examples of those who display the syndrome of temporary insanity. Temporary insanity is a true psychosis though of but brief duration. Moral responsibility is non-existent in cases of true temporary insanity.

b) *Prolonged grave deviations from normalcy.* This type of individual over an extended period of time thinks, reasons, and wills in a manner gravely at variance with rationally accepted procedure.

It becomes second nature for such an individual to think in this warped way and to act in harmony with his ill-organized thinking. His thought processes crystallize into irrational judgments and his psychic life becomes dominated by delusions, emotions, complexes, and hallucinations. Schizophrenes and pure paranoids may be cited as examples of those who gravely deviate from normalcy for a prolonged period.

3. *Psychoses may result in delusions and in seriously irregular conduct.*

a) *Delusions.* Delusions, or false judgments, are found in all types of psychoses. Proper, also, to all types of psychoses except pure paranoia and probably simple schizophrenia are hallucinations.

b) *Seriously irregular conduct and behavior.* The individual who is governed by delusions and hallucinations is not in a condition to practice self-control. Hence his conduct is out of harmony with the mode of activity found in the lives of men whose conduct is more rational. Examples of irregular conduct and behavior are grave despondency, euphoria, destruction of property, attempts at suicide, and kindred actions.

4. *Personality change.*

Perhaps the most outstanding characteristic of a psychosis is the deep-seated personality change that occurs. The way of thinking, judging, reasoning, and willing of those thus affected seems to undergo radical change. This radical change is manifested in a number of ways and is very impressive. Psychotic patients frequently assume attitudes quite contradictory to their usual way of thinking and acting. The reticent may become garrulous, or vice versa; the chaste often become obscene; the affectionate become passive and indifferent, etc. Their emotional life undergoes a transformation.

5. *And other symptoms.*

a) *Defective insight.* The patient is incapable for the most part of realizing that his mind is affected. While in the psychotic condition he does not and cannot be induced to understand the abnormal nature of his symptoms. Even the partial restoration of insight is generally an indication of returning normalcy.

b) *Loss of contact with reality.* Psychotics gradually lose touch with reality, with the world around them, with the domain of facts and daily happenings. The world for these does not have the "feeling of reality." The psychotic moves as though he were in a dreamland of imagery and complexes.

c) *Lack of orientation.* Lack of orientation, i.e., inability to realize circumstances of time and place and persons is another common indication of serious abnormalcy. This pathological condition presupposes a number of disordered mental processes. Pure paranoics are, however, perfectly oriented, but practically all other types of mental patients manifest disorientation.

d) *Distortion of the psychic functions.* The intellect in some psychotic individuals is incapable of performing some or all of its functions or is capable of doing so only defectively. Understanding, reasoning, memory, or imagination may all be affected.

SUMMARY OF THE CHARACTERISTICS OF PSYCHOSES

1. Temporary or prolonged.
2. Disturbed or inappropriate emotions.
3. Seriously irregular conduct.
4. Personality change.
5. Defective insight.
6. Loss of contact with reality.
7. Lack of orientation.
8. Delusions and frequently hallucinations.
9. Distortion of the psychic functions.

DIFFERENCES BETWEEN THE PSYCHOTICS AND NEUROTICS

1. The psychotic undergoes a grave personality change; not so, however, the neurotic. The neurotic is his former self but is modified by inferiority complexes, fear, exhaustion, or a loss of some function.

2. Lack of insight or of practical understanding as to his plight is characteristic of the psychotic. He does not realize the seriousness of his condition. The neurotic is aware of his mental problem and can often discourse intelligently about it.

3. The psychotic preserves poor contact with the realities of life. The neurotic is keenly aware of them, although pathologically interested in escaping those that bring pain.

4. The psychotics with the exception of pure paranoics are usually considerably disoriented, and this in practically all spheres. The neurotic, on the contrary, is well oriented for time, place, and persons.

5. The intellectual, emotional, and volitional aspects of the psychotics are deeply disturbed. This is not true of the neurotic. His psychic powers of thinking and willing are well preserved.

NEUROSES AND PSYCHOSES DIFFER ONLY IN DEGREE

Psychic symptoms are assumed by individuals because they feel the need of escape from unsolved conflicts and problems. They consider it easier to bear the symptoms of neurosis than to endure the tension and pain consequent on the inadequate solution of problems, real or imaginary. To the neurotic his symptoms seem good, useful, desirable, and to be cherished. He may cling to such symptoms and resist all attempts for their removal. They offer protection.

But even these neurotic devices are sometimes inadequate. The unresolved conflict remains. Since the neurotic cannot face his problems in a rational way, further withdrawal from reality becomes necessary. And so, slowly, imperceptibly, he develops a philosophy of life, a feeling tone, wishful thinking, which facilitates further regression. He withdraws into a life of images, complexes, hallucinations, and delusions. This is a psychosis. The transition from one state to the other is gradual. The two would seem to differ not essentially, but only in degree.

OTHER NAMES FOR PSYCHOSES

1. *Insanity* is the legal term for grave mental disorder. Psychiatrists and psychologists prefer not to use it. Insanity connotes or emphasizes the socioeconomic aspects of psychotic disorders and the necessity of institutionalization.

2. *Lunacy* is an obsolete word for psychosis.

3. *Dementia* is employed in the sense of psychosis, but often to signify apparent mental deterioration and loss of intelligence appearing in certain patients. Dementia signifies the psychic regression found in the psychotics.

BORDERLINE STATES

Besides the large number of classifiable disorders, there exist many unclassifiable cases which occupy in Cobb's⁸ terminology the "Borderlands of Psychiatry."

The general characteristic of this group is the lack of definite outstanding symptoms or signs which enable the observer to assign it to one of the generally accepted syndromes. Such are certain schizoid episodes that never become full-blown mental disorders, inchoative psychoses in the prodromal stage that do later take more

definite shape, and certain cases of mental disturbances so mild as not to warrant classification. Many other people may be well on the way to some pathological state of mind such as habitual drunkards, people afflicted with syphilis, and others.

CASE 28: *Borderline Case*

Julia was the eighth of nine children, mostly girls, who lived in the Middle West. From early childhood, she manifested traits that augured poorly for the future. She habitually indulged in tantrums to get what she wanted and to avoid unpleasant duties. This policy was carried into school. She made few friends. She was striking in physical beauty and as she grew older spent a great deal of time on her person. She grew into womanhood, lonely, arrogant, handsome, self-willed. She married a neighbor of backward personality and moved west, where they remained thirty years. They had three children, one a son who became a dissipated, selfish individual; one daughter who developed into a sighing, grumbling, never-to-be-satisfied wife; another daughter, the identical reproduction of the mother, all three hating the world and dissatisfied with themselves. Julia developed into a scold incarnate, a chronic crank and troublesome neighbor; the husband into a passive drunkard who spent his life sitting in the corner and staring into space.

Number of Borderline Cases

There is good reason to suspect that the number of borderline cases far outnumber those who are placed in the conventional forms or classes. They comprise a large group who are in need of much psychiatric treatment. Dr. Stanley Cobb⁹ estimates that there are at the present time in this country about six and one-half million "partially incapacitated" persons who inhabit the "borderlands of psychiatry." Borderland cases include those people who suffer from mental disorders not serious enough nor sufficiently developed to warrant commitment to an institution. Cobb includes psychoneurosis, epilepsy, stammering, and alcoholism in this group. Because of their great numbers, they deserve the serious attention of those who can help. Furthermore, most of them are the type that could profit greatly by therapeutic and constructive psychiatry or mental hygiene. The student will gather a sufficient knowledge of their nature and needs by familiarizing himself with the neuroses and psychoses. His knowledge of clinical material will enable him to perceive the applicability and adaptability of this to borderline cases.

NEW DIAGNOSTIC NOMENCLATURE OF MENTAL DISORDERS¹⁰

0- DISEASES OF THE PSYCHOBIOLOGIC UNIT¹¹

INTRODUCTION

Previous changes of the Psychobiologic unit have been restricted by the timing of each revision. This revision is perfectly timed to include the experiences of psychiatrists of World War II, the results of several years usage by the military and Veterans Administration of a revised army nomenclature, the pattern of a new international code and the results of several years deliberation of the Nomenclature Committee of the American Psychiatric Association. As a result of all these we were enabled to offer a completely new classification in conformity with newer scientific and clinical knowledge, simpler in structure, easier to use and virtually identical with other national and international nomenclatures.

Qualifying Phrases

- .x1 With psychotic reaction
- .x2 With neurotic reaction
- .x3 With behavioral reaction

The above qualifying phrases may be added to any diagnosis in the Psychobiologic Unit when needed to further define or describe the clinical picture. They will not be used where such use is redundant. In general, the phrase will be redundant when it repeats the major heading of any group of diagnosis, for example:

- .x1 is redundant when used with a diagnosis listed under Psychotic Disorders
- .x2 is redundant when used with Psychoneurotic Disorders
- .x3 is redundant when used with Personality Disorders

A qualifying phrase is not ordinarily needed with any diagnosis in the group of acute organic brain disorders, as the diagnosis itself implies a delirium, a temporary psychotic state.

DISORDERS CAUSED BY OR ASSOCIATED WITH IMPAIRMENT OF BRAIN TISSUE FUNCTION

(Note: The number in parentheses in the right hand margin is the appropriate code number from the International Statistical Classification, Appendix A.)

ACUTE BRAIN DISORDERS

—1 DISORDERS DUE TO OR ASSOCIATED WITH INFECTION

- 009-100 Acute Brain Syndrome associated with intracranial infection. *Specify infection* (308.5)*
- 000-100 Acute Brain Syndrome associated with systemic infection. *Specify infection* (308.3)*

—3 DISORDERS DUE TO OR ASSOCIATED WITH INTOXICATION

- 000-3.. Acute Brain Syndrome, drug or poison intoxication. *Specify drug or poison* (308.5)*
- 000-3312 Acute Brain Syndrome, alcohol intoxication (307)*
- 000-33122 Acute hallucinosis (307)
- 000-33123 Delirium tremens (307)

—4 DISORDERS DUE TO OR ASSOCIATED WITH TRAUMA

- 000-4.. Acute Brain Syndrome associated with trauma. *Specify trauma* (308.2)*

—50 DISORDERS DUE TO OR ASSOCIATED WITH CIRCULATORY DISTURBANCE

- 000-5.. Acute Brain Syndrome associated with circulatory disturbance. (*Indicate cardiovascular disease as additional diagnosis*) (308.4)*

—55 DISORDERS DUE TO OR ASSOCIATED WITH DISTURBANCE OF INNERVATION OR OF PSYCHIC CONTROL

- 000-550 Acute Brain Syndrome associated with convulsive disorder. (*Indicate manifestation by Supplementary Term*) (308.1)*

—7 DISORDERS DUE TO OR ASSOCIATED WITH DISTURBANCE OF METABOLISM, GROWTH OR NUTRITION

- 000-7.. Acute Brain Syndrome with metabolic disturbance. *Specify* (308.5)*

* An asterisk on any International number in this classification indicates that some further explanation is given about that category in the Appendix to the Standard Nomenclature and International Statistical Classification included in *Standard Nomenclature of Diseases and Operations*, Fourth Edition, published for the American Medical Association, The Blakistone Company, Philadelphia, 1952.

- 8 DISORDERS DUE TO OR ASSOCIATED WITH NEW GROWTH
 000-8.. Acute Brain Syndrome associated with intra-cranial neoplasm. *Specify* (308.0)*
- 9 DISORDERS DUE TO UNKNOWN OR UNCERTAIN CAUSE
 000-900 Acute Brain Syndrome with disease of unknown or uncertain cause. (*Indicate disease as additional diagnosis*) (308.5)*
- X DISORDERS DUE TO UNKNOWN OR UNCERTAIN CAUSE WITH THE FUNCTIONAL REACTION ALONE MANIFEST
 000-xx0 Acute Brain Syndrome of unknown cause (309.1)*

CHRONIC BRAIN DISORDERS¹²

- 0 DISORDERS DUE TO PRENATAL (CONSTITUTIONAL) INFLUENCE
 009-0.. Chronic Brain Syndrome associated with congenital cranial anomaly. *Specify anomaly* (328.0)*
 009-016 Chronic Brain Syndrome associated with congenital spastic paraplegia (328.0)*
 009-071 Chronic Brain Syndrome associated with Mongolism (328.0)*
 009-052 Chronic Brain Syndrome due to prenatal maternal infectious diseases (328.0)*
- 1 DISORDERS DUE TO OR ASSOCIATED WITH INFECTION
 0..-147.0 Chronic Brain Syndrome associated with central nervous system syphilis. *Specify as below* (026.9)*
 009-147.0 Meningoencephalitic (025.9)*
 004-147.0 Meningovascular (026.9)*
 0y0-147.0 Other central nervous system syphilis (026.9)*
 009-1...0 Chronic Brain Syndrome associated with intra-cranial infection other than syphilis. *Specify infection*¹³ (328.1)*
- 3 DISORDERS ASSOCIATED WITH INTOXICATION
 009-300 Chronic Brain Syndrome associated with intoxication (328.2)*
 009-3.. Chronic Brain Syndrome, drug or poison intoxication. *Specify drug or poison* (328.2)*
 009-3312 Chronic Brain Syndrome, alcohol intoxication. *Specify reaction .x1, .x2, .x3 when known* (322.9)*

—4 DISORDERS ASSOCIATED WITH TRAUMA

- 009-050 Chronic Brain Syndrome associated with birth trauma (328.3)*
- 009-400 Chronic Brain Syndrome associated with brain trauma (328.4)*
- 009-4.. Chronic Brain Syndrome, brain trauma, gross force. *Specify. (Other than operative)* (328.4)*
- 009-415 Chronic Brain Syndrome following brain operation (328.4)*
- 009-462 Chronic Brain Syndrome following electrical brain trauma (328.4)*
- 009-470 Chronic Brain Syndrome following irradiational brain trauma (328.4)*

—5 DISORDERS ASSOCIATED WITH CIRCULATORY DISTURBANCES

- 009-516 Chronic Brain Syndrome associated with cerebral arteriosclerosis (328.5)*
- 009-5.. Chronic Brain Syndrome associated with circulatory disturbance other than cerebral arteriosclerosis. *Specify* (328.6)*

—55 DISORDERS ASSOCIATED WITH DISTURBANCES OF INNERVATION OR OF PSYCHIC CONTROL

- 009-550 Chronic Brain Syndrome associated with convulsive disorder (353.9)*

—7 DISORDERS ASSOCIATED WITH DISTURBANCE OF METABOLISM, GROWTH OR NUTRITION

- 009-79x Chronic Brain Syndrome associated with senile brain disease (794.9)*
- 009-700 Chronic Brain Syndrome associated with other disturbance of metabolism, growth or nutrition. (Includes presenile, glandular, pellagra, familial amaurosis) (328.8)*

—8 DISORDERS ASSOCIATED WITH NEW GROWTH

- 009-8.. Chronic Brain Syndrome associated with intracranial neoplasm. *Specify neoplasm* (328.9)*

9 DISORDERS ASSOCIATED WITH UNKNOWN OR UNCERTAIN CAUSE

- 009-900 Chronic Brain Syndrome associated with diseases of unknown or uncertain cause. (Includes multiple sclerosis, Huntington's chorea, Pick's disease, and other diseases)

of a familial or hereditary nature.) *Indicate disease by additional diagnosis* (328.9)*

—X DISORDERS DUE TO UNKNOWN OR UNCERTAIN CAUSE WITH
THE FUNCTIONAL REACTION ALONE MANIFEST

009-xx0 Chronic Brain Syndrome of unknown cause (328.9)*

MENTAL DEFICIENCY¹⁴

—X DISORDERS DUE TO UNKNOWN OR UNCERTAIN CAUSE WITH
THE FUNCTIONAL REACTION ALONE MANIFEST; HEREDITARY
AND FAMILIAL DISEASES OF THIS NATURE

000-x90 Mental deficiency (familial or hereditary) (325.5)*

000-x901 Mild (325.3)*

000-x902 Moderate (325.2)*

000-x903 Severe (325.1)*

—y DISORDERS DUE TO UNDETERMINED CAUSE

000-y90 Mental deficiency, idiopathic (325.5)*

000-y901 Mild (325.3)*

000-y902 Moderate (325.2)*

000-y903 Severe (325.1)*

DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED PHYSICAL CAUSE OR STRUCTURAL CHANGE IN THE BRAIN

PSYCHOTIC DISORDERS

—7 DISORDERS DUE TO DISTURBANCE OF METABOLISM, GROWTH,
NUTRITION OR ENDOCRINE FUNCTION

000-796 Involutional psychotic reaction (302)

—X DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY
DEFINED TANGIBLE CAUSE OR STRUCTURAL CHANGE

000-x10 Affective reactions (301.2)

000-x11 Manic depressive reaction, manic type (301.0)

000-x12 Manic depressive reaction, depressive type (301.1)

000-x13 Manic depressive reaction, other (301.2)

000-x14 Psychotic depressive reaction (309.0)*

000-x20 Schizophrenic reactions (300.7)*

000-x21 Schizophrenic reaction, simple type (300.0)

000-x22 Schizophrenic reaction, hebephrenic type (300.1)

000-x23 Schizophrenic reaction, catatonic type (300.2)

000-x24 Schizophrenic reaction, paranoid type (300.3)

000-x25 Schizophrenic reaction, acute undifferentiated type (300.4)

000-x26	Schizophrenic reaction, chronic undifferentiated type	(300.7)
000-x27	Schizophrenic reaction, schizo-affective type	(300.6)
000-x28	Schizophrenic reaction, childhood type	(300.8)*
000-x29	Schizophrenic reaction, residual type	(300.5)
000-x30	Paranoid reactions	(303)
000-x31	Paranoia	(303)
000-x32	Paranoid state	(303)
000-xy0	Psychotic reaction without clearly defined structural change, other than above	(309.1)*

PSYCHOPHYSIOLOGIC AUTONOMIC AND VISCERAL DISORDERS

—55 DISORDERS DUE TO DISTURBANCE OF INNERVATION OR OF PSYCHIC CONTROL

001-580	Psychophysiologic skin reaction. (<i>Indicate manifestation by Supplementary Term</i>)	(317.3)*
002-580	Psychophysiologic musculoskeletal reaction. (<i>Indicate manifestation by Supplementary Term</i>)	(317.4)
003-580	Psychophysiologic respiratory reaction. (<i>Indicate manifestation by Supplementary Term</i>)	(317.0)
004-580	Psychophysiologic cardiovascular reaction. (<i>Indicate manifestation by Supplementary Term</i>)	(315.2)*
005-580	Psychophysiologic hemic and lymphatic reaction. (<i>Indicate manifestation by Supplementary Term</i>)	(317.5)
006-580	Psychophysiologic gastrointestinal reaction. (<i>Indicate manifestation by Supplementary Term</i>)	(316.3)*
007-580	Psychophysiologic genito-urinary reaction. (<i>Indicate manifestation by Supplementary Term</i>)	(317.1)*
008-580	Psychophysiologic endocrine reaction. (<i>Indicate manifestation by Supplementary Term</i>)	(317.5)
009-580	Psychophysiologic nervous system reaction. (<i>Indicate manifestation by Supplementary Term</i>)	(318.3)*
00x-580	Psychophysiologic reaction of organs of special sense. (<i>Indicate manifestation by Supplementary Term</i>)	(317.5)

PSYCHONEUROTIC DISORDERS

—X DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY
DEFINED TANGIBLE CAUSE OR STRUCTURAL CHANGE

000-x00	Psychoneurotic reactions	(318.5)*
000-x01	Anxiety reaction	(310)
000-x02	Dissociative reaction	(311)
000-x03	Conversion reaction	(311)
000-x04	Phobic reaction	(312)
000-x05	Obsessive compulsive reaction	(313)
000-x06	Depressive reaction	(314)
000-x0y	Psychoneurotic reaction, other	(318.5)*

PERSONALITY DISORDERS

—X DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY
DEFINED TANGIBLE CAUSE OR STRUCTURAL CHANGE

000-x40	Personality pattern disturbance	(320.7)*
000-x41	Inadequate personality	(320.3)
000-x42	Schizoid personality	(320.0)
000-x43	Cyclothymic personality	(320.2)
000-x44	Paranoid personality	(320.1)
000-x50	Personality trait disturbance	(321.5)*
000-x51	Emotionally unstable personality	(321.0)
000-x52	Passive-aggressive personality	(321.1)*
000-x53	Compulsive personality	(321.5)
000-x5y	Personality trait disturbance, other	(321.5)*
000-x60	Sociopathic personality disturbance	(320.7)*
000-x61	Antisocial reaction	(320.4)
000-x62	Dyssocial reaction	(320.5)
000-x63	Sexual deviation. <i>Specify Supplementary</i>	
	<i>Term</i>	(320.6)
000-x64	Addiction	
000-x641	Alcoholism	(322.1)
000-x642	Drug addiction	(323)
000-x70	Special symptom reactions	(321.4)*
000-x71	Learning disturbance	(326.0)*
000-x72	Speech disturbance	(326.2)*
000-x73	Enuresis	(321.3)
000-x74	Somnambulism	(321.4)
000-x7y	Other	(321.4)*

TRANSIENT SITUATIONAL PERSONALITY DISORDERS

000-x80	Transient situational personality disturbance	(326.4)*
000-x81	Gross stress reaction	(326.3)*
000-x82	Adult situational reaction	(326.6)*
000-x83	Adjustment reaction of infancy	(324.0)*
000-x84	Adjustment reaction of childhood	(324.1)*
000-x841	Habit disturbance	(324.1)*
000-x842	Conduct disturbance	(324.1)*
000-x843	Neurotic traits	(324.1)*
000-x85	Adjustment reaction of adolescence	(324.2)*
000-x86	Adjustment reaction of late life	(326.5)*

NONDIAGNOSTIC TERMS FOR HOSPITAL RECORD

011-332	Alcoholic intoxication (simple drunkenness)	(322.0)
y00-y01	Boarder	(Y09)*
y00-yyy	Dead on admission	(795.5)
y00-y00	Diagnosis deferred. <i>Change as many of first three digits as possible, to indicate site</i>	(795.5)
y00-000	Disease none. <i>Change first digit to indicate suspected system if any</i>	(793.2)*
y00-002	Examination only. <i>Change first three digits as needed</i>	(Y00.0)
y00-004	Experiment only. <i>Change first three digits as needed</i>	(Y09)
y00-005	Malingering	(795.1)
y00-001	Observation. <i>Change first three digits as needed</i>	(793.2)*
y00-003	Tests only. <i>Change first three digits as needed</i>	(Y00.3)*

SUMMARY

This is an important chapter. In spite of the very real difficulty in satisfactorily defining a psychosis each individual should clearly formulate and understand in his own mind a good working definition. As we have previously indicated neuroses and psychoses differ quantitatively and not qualitatively. The dividing line between them is not always clear and it is possible for even experts to disagree in certain borderline cases. If the points of difference indicated in this chapter are carefully studied most cases will be easily differentiated.

FOOTNOTES

1. Quoted by Albert Deutsch from William G. M. Cook, *Insanity and Mental Deficiency in Relation to Legal Responsibility* (London: G. Routledge & Sons, Ltd., 1921), as quoted by Joseph W. Eaton, "The Assessment of Mental Health," *American Journal of Psychiatry*, 108:2, August, 1951, p. 88.

2. Hinsie and Shatzky, *Psychiatric Dictionary*, 2 ed. with Supplement (Oxford Medical Publications, 1953), p. 447.
3. Henry A. Davidson, *Forensic Psychiatry* (New York: Ronald Press Co., 1952), p. 3.
4. *Outline of Neuropsychiatry in Aviation Medicine*, War Department Technical Manual, TM 8-325, 1940, p. 32.
5. Edward G. Billings, *A Handbook of Elementary Psychobiology and Psychiatry* (New York: The Macmillan Co., 1939), p. 94.
6. Ian Skottowe, *Clinical Psychiatry* (New York: McGraw-Hill Book Co., Inc., 1954), p. 21.
7. Arthur P. Noyes and Edith M. Haydon, *A Textbook of Psychiatry* (New York: The Macmillan Co., 1940), p. 305.
8. Stanley Cobb, *Borderlands of Psychiatry* (Cambridge: Harvard University Press, 1944).
9. *Ibid.*
10. American Psychiatric Association, Mental Hospital Service, *Diagnostic and Statistical Manual of Mental Disorders*, 1952.
11. Reprinted from "Standard Nomenclature of Diseases and Operations," 4 ed., published for American Medical Association (Philadelphia: Blakistone Co., 1952).
12. The qualifying phrase "Mental Deficiency" .x4 (mild .x41, moderate .x42, or severe .x43) should be added at the end of the diagnosis in disorders of this group which present mental deficiency as the major symptom of the disorder. Include intelligence quotient (I.Q.) in the diagnosis.
13. When infection is more important than the reaction or mental deficiency, specify the infection. If both infection and reaction or mental deficiency are important two diagnoses are required.
14. Include intelligence quotient (I.Q.) in the diagnosis.

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THE SCHIZOPHRENIAS (DEMENTIA PRAECOX)

DEFINITION

The schizophrenias are a group of psychoses, psychogenic in origin, exhibiting a great number and variety of symptoms, but chiefly characterized by the habit of pathological regression and emotional apathy.

Like all definitions, this one needs careful delineation, lest the terms used within its structure be misapplied or misunderstood.

The schizophrenias are referred to as a "group" because of the fact that there is a great variety of disorders which can be identified by the single term, since certain common characteristics are found in all of them. *Contemporary psychiatrists now generally recognize four distinct and quite extensive variations of the schizophrenic pattern: the simple, the hebephrenic, the catatonic, and the paranoid.* Each of these groups will be discussed more in detail later when typical cases of each will be examined.

It must be borne in mind, however, that some types of schizophrenia present symptoms that are characteristic of two or more of these categories. This intermingling of symptoms renders each problem extremely complex; hence, the student should be alerted to the complexity.

The schizophrenias are called a group of "psychoses" precisely because they are not ultimately explicable in terms of organic disease; they are rather a personality maladjustment or distortion which terminates in serious malfunctioning of the intellect, the will, and the emotions. Hence, they cannot be rightly understood save in light of the intellect, the will, and the emotions of the human person. Even the gravest symptoms of this disease are only intelligible in terms of personality imbalance: pathological regression, apathy, hallucinations, delusions, and many others to be enumerated under the more specific treatment of schizophrenic symptoms.

The definition states that schizophrenia has "psychogenic origin," and thus denies that its origin can be found in pathological tissue or in a diseased organism or in a toxic state. It arises from faulty habits of thinking and willing and from undue influence of the

emotions and complexes. This element of the psychogenic etiology of schizophrenia must be discussed more at length in a later part of this chapter.

One of the specifying qualities of the disorder is "pathological regression." The common understanding of the term "regression" is a general going backward, a retreat from a former position. Pathological regression in the psychic sense used in this definition implies three important elements: (1) awareness of a conflict, (2) unwillingness or inability to meet the conflict, (3) withdrawal from reality to a lower level of psychic living.

1. Because of complexes, displacements, and kindred psychological factors, the conflict, apart from being present, may not be too clear in all its details. The conflict may have had its origin in unsuccessful childhood attempts to cope with environment. The memory of these unsuccessful childhood attempts continues to perpetuate itself as an irritating sense or even conviction of failure, frustration, fear, and inferiority. Despite the possible obscurity of its constitutive elements the actual existence of the conflict is recognized by the individual.

2. The individual in the presence of his conflicts seems unable to decide in favor of a definite efficient line of conduct. By now this attitude seems to have become more or less habitual in his life. The entire situation is surrounded by emotions and complexes, and so proves bewildering to him. The practical intellect indicates a solution to the conflict if only the individual could be induced to follow its direction. The powers of the intellect in these cases are deeply eclipsed by the shadows of indecision, emotion, confusion, and incertitude that envelop the individual's psychic life.

3. The third integral element of regression is a withdrawal from reality, from truth, from the world of facts and daily happenings, from the distasteful and apparently insurmountable conflicts that engulf him and threaten to submerge him. This withdrawal from reality means an interior moving away from the memory of defeats, failures, frustrations, deflations, feelings of unworthiness, and social incompetence. This withdrawal from reality, which is the negative aspect of the situation, implies further a positive tendency toward inefficient thinking, judging, and reasoning; toward meeting life's conflicts by imaginary solutions rather than by actual accomplishment. In this fanciful irrational psychic domain the individual finds a solution to his conflicts but, unfortunately, a solution that is dictated by wishful thinking. In such instances his imagination becomes his

preceptor, while his reason, though basically preserved, becomes inoperative. From pathological imagery the way is open, short, and easy to complexes, delusions, hallucinations, and a psychosis.

Such is the regression which characterizes the schizophrenic. It is a disorder precisely because it is an exaggerated extreme of something in itself good and useful. The normal person frequently enough makes use of regressional flights in a salutary fashion and with careful normalcy. The mechanism of regression is not in itself dangerous; it is only its pathological use that renders it so. This excessive use is dangerous because it attacks the integrity of the human personality.

Pathological regression means a return to a lower level of psychic living. It still includes all types of psychic activity and must not be restricted merely to a return to sense knowledge.

The motivation which structures the conduct of the individual into an acceptance of the elements that lead to pathological regression is derived mainly from his past experiences. He has met and experienced what in his opinion has been failure, and failure is unpleasant, and begets ego deflation, insecurity, and frustration. The schizophrenic in regressing seeks ease, security, a cessation of problems and psychic relief at all costs.

The pathological regression here described is different from that put forth by William A. White, who considers the patient suffering from dementia praecox as living the early history of the race. "We are not able," he says, "to feel ourselves into the position which the praecox patient occupies with relation to the world; we do not understand what he says; we do not comprehend the meanings of his symbols; he seems to us outside the plane of our experience. This is because his symptoms hark back to a period of which we have no recollection. They do not, as they so frequently do in manic-depressive psychosis and in hysteria, go back and re-animate well-organized experiences of early childhood, adolescence or youth, but they dip down still further and tap the ultimate sources of our psychic integrations, and so may be as different from psychological experiences as we know them, as hydrogen and oxygen are different from water."¹

The final element in the definition of schizophrenias is the second prominent symptom or characteristic, namely *emotional apathy and indifference*. This apathy, this indifference, this emotional blunting is the inevitable result of pathological indulgence in the mechanism of regression. This poverty of feeling tone is so important a symptom

of the schizophrenic that it will demand more detailed study later in this chapter.

HISTORY OF SCHIZOPHRENIA

The general lineaments of schizophrenia can be found in psychiatric literature dating back a hundred years or more. The earliest picture drawn can still be applied with profit to the typical contemporary schizophrenic. That picture contained the details of regression, withdrawal, apathy, indifference, indolence, and refusal to follow routine. The patient was shown to fulfill his tasks mechanically, without zest or pleasure. An atmosphere of passivity enveloped him.

Young persons not infrequently fall into a state somewhat resembling melancholia, without any discoverable cause of sorrow, and certainly without any specific grief; they become indolent or pursue their usual occupations or recreations mechanically and without interest; the intellect, the affections, the passions, all seem inactive or deadened and the patients become utterly apathetic.²

This description of Conolly almost a hundred years ago enumerated most of the classic symptoms of the schizophrenic.

Term "Dementia Praecox" First Used About 1860. The term "dementia praecox" was first used in 1860 by B. A. Morel, a Belgian psychiatrist, in his analysis of a case history. The subject of the history was an undersized boy who, because of defective physical development, and in spite of superior intellectual talents, began to detest his father.

Out of embarrassment arising from his stunted growth, this boy began to avoid company and became regressive, introspective, taciturn, and shy. His psychic powers became stagnant; his memory of recent events defective. He forgot practically all that he had previously acquired.

Morel, a materialistic advocate of the then accepted theory of degeneration, attributed the boy's disorder to the mentally diseased condition of his mother. She had been psychotic for many years. Dr. Morel called it "dementia praecox."

Hebephrenia. An important step which helped toward the clarification of the contemporary syndrome of dementia praecox (later to be called "schizophrenia") was taken in 1871 when Hecker isolated *hebephrenia* and described its etiology, symptoms, course, and prognosis. Preliminary studies had been made by Kahlbaum almost ten

years earlier, but it was Hecker who showed that hebephrenia is especially distinguished by silliness; later it was frequently called the "silly dementia."

Catatonia. In 1874, Kahlbaum isolated *catatonia*, by establishing three symptoms which identify the disease:

1. Melancholia, which represents the end result of prolonged contact with unpleasant conditions;
2. Mania, which follows melancholia and usually indicates its temporary cessation;
3. Stupor, which he associated with *cereæ flexibilitas*, or atonicity, or melancholia atonita.

This new category, although it has much in common with hebephrenia as described by Hecker, is distinguished from the former disorder by the absence of silliness.

Paranoia. *Paranoia* was isolated definitely by Kraepelin in 1893. Prior to his time there were numerous types of paranoia described in psychiatric literature, but the outlines were vague and the syndrome indefinite. It is not surprising that there was considerable controversy for a time about the nature of the newly described disorder. Under the paranoid syndrome Kraepelin placed mental disorders which were characterized by (1) nonsystematized delusions of grandeur or persecution; (2) consistent hallucinations; and (3) little or no clouding of consciousness.

Dementia praecox. Then, in 1899, Kraepelin grouped together under the heading *dementia praecox* the three disorders which had just been isolated, namely, hebephrenia, catatonia, and paranoia. These three disorders had, according to him, these elements in common: appearance in relatively early years of life, and a progressive development of the disorder until dementia was finally reached.

Sejunction. Dissociation was first mentioned by Wernicke in 1900. He called it "sejunction," which meant for him the process which results in the lesion of the structure supporting brain association. This state was produced, according to him, by an acute organic brain defect. This sejunction was supposed to explain the symptoms of schizophrenia.

Intrapsychic ataxia. In 1909, Stransky wrote that *dementia praecox* resulted from a lack of psychic co-ordination among the powers of man, i.e., his intellect, will, and emotions. This condition he called "intrapsychic ataxia." The lack of co-ordination may be illustrated, Stransky explained, by the lack of proper proportion between the

stimulus and response in the patients suffering from the disease. A patient, for example, was told that one of his relatives had just died; he responded with hilarious laughter. On the other hand, he was given news of great good fortune; he responded with tears.

Stransky treated these phenomena as dissociations of the whole psyche. He claimed that they were emotional rather than intellectual and were caused by deep-seated disorders of the physiologically co-ordinated association of intellectual and emotional activities.

Schizophrenia. The term "schizophrenia" was coined by Bleuler in 1911. He was a confirmed materialist. He thought the term "dementia praecox" was not a happily chosen name for that particular group of disorders. Under the term "schizophrenia" he includes

Many atypical melancholias and manias of other schools (especially nearly all "hysterical" melancholias and manias), most hallucinatory confusions, much that is elsewhere called amentia, a part of the forms consigned to delirium acutum, motility psychoses of Wernicke, primary and secondary dementias without special names, most of the paranoias of other schools, especially all hysterically crazy, nearly all incurable "hypochondriacs," some "nervous people" and compulsive and impulsive patients. The diseases especially distinguished as juvenile and masturbatory forms all belong here, also a large part of the puberty psychoses, and the degeneration psychoses of Magnans. Many prison psychoses and the Ganser twilight states are acute syndromes based on a chronic schizophrenia.³

Bleuler thus "introduced the term 'schizophrenia' to designate all cases of functional mental disturbance with the exception of typical manic-depressive cases. He suggested that all such conditions as dementia praecox, paranoid states, hallucinoses, prison psychoses, and conditions which might be referred to as abnormalities of makeup were manifestations of one underlying morbid process, which could be briefly characterized as a 'splitting of the personality'" (Henderson and Gillespie).

He further described the disorder as one that "may come to a standstill at every stage and many of its symptoms may clear up very much or altogether; but if it progresses, it leads to a dementia of a definite character."

Bleuler included under the term "schizophrenia" much more than Kraepelin had meant by "dementia praecox." They were hardly talking about the same disorder. It was inevitable that fewer of Bleuler's patients should progress toward dementia, and that more

of them should recuperate. He established the use of the new term with the careful words: "As the disease need not progress as far as dementia and does not always appear praecociter, *i.e.*, during puberty or soon after, I prefer the name schizophrenia."⁴

ETIOLOGY

Age of Onset

In general, the onset of schizophrenia occurs between the ages of 18 and 35. The age distribution is as follows:

Under 15 years	2 per cent
15 to 20 years	10 per cent
21 to 29 years	20 per cent
30 to 34 years	15 per cent
35 to 39 years	12 per cent
40 to 44 years	7 per cent
45 to 48 years	5.3 per cent
49 years and later	8.7 per cent

It will be remembered that Kraepelin maintained that this disorder began in the early years of life, and proceeded to complete mental deterioration. In his opinion the majority of cases occurred between the ages of 14 and 25. Bleuler, on the contrary, held that the disorder might occur outside the years of youth and did not necessarily proceed to deterioration. These opinions are reflected in the tables of incidence.

Early Appearance

The disorder appears most frequently during the second, third, or fourth decades of life. The highest rate of incidence is in the second decade. It strikes, therefore, in the very prime of life. The early onset of this disorder gave rise to the term dementia praecox, or early dementia. This term is somewhat of a misnomer, however, for the disorder may develop as late as the fourth decade. This is especially true of paranoid dementia praecox. Nevertheless, the later appearance is less common than the early. In a very real sense, the disorder is a disorder of youth [Kuntz].⁵

About 70% of the cases occur between the ages of fifteen and thirty [Strecker].⁶

. . . The vast majority are under thirty years of age. . . The onset of this disorder, with a few exceptions, occurs between the eighteenth and thirty-fifth years. . . [Sadler].⁷

Most of them become manifest from puberty up to the twenty-fifth year; from thirty on, the morbidity sinks rapidly to rise again, in women, to a low second peak at the time of the climacterium. Only the chronic paranoid forms show a preference for breaking out rather late, especially around the fourth decade [Bleuler].⁸

The 92 males with dementia praecox had an average age of 32.3 years at the time of admission to the Utica State Hospital. The 83 females were older, their average age at admission being 35.2 years [Pollock].⁹

From the above it is evident that Kraepelin has his followers who claim that this psychosis is truly praecox, the 14 to 25 years bracket. The vast majority, however, in assigning the age of incidence follow the opinion of Bleuler and state that the disorder may occur any time from adolescence to past middle age. Passing comment on the various age brackets as attributed to dementia praecox or schizophrenia, May observes that it "would not appear to suggest an adolescent origin for this disease to the extent advocated in our textbooks."¹⁰

Frequency

It is estimated that in the United States between 75,000 and 80,000 new patients are admitted annually to institutions for the mentally ill. About 15-20 per cent of these are schizophrenes. Because of the tendency toward longevity of these patients and the comparatively small number of permanent remissions and cures, schizophrenic patients constitute between 50 per cent and 60 per cent of the total population of mental hospitals. About 52 per cent of these patients are women; 48 per cent are men.

Heredity

Many psychiatrists have singled out heredity as the most prominent cause of schizophrenia. However, experimental studies of heredity are rapidly approaching the conclusion that there is no basis for this opinion. To date, no evidence has been unearthed to establish the fact that heredity is the cause of schizophrenia or any other mental disorder. The following facts, as set forth by Cameron, seem to be the only conclusions that may be legitimately drawn from studies of heredity as the causative factor in schizophrenia:

1. That patients are not born with the disorder, but become affected between the ages of 5 and 60, clearly indicating the influence of environment in determining the appearance of schizophrenia;

2. That the children of schizophrenic parents are not always or necessarily affected likewise;
3. That the disorder may disappear spontaneously;
4. That therapeutic measures, both physical and psychic, often effect complete or partial, permanent or temporary cures.

The Committee of the American Neurological Association for the investigation of eugenical sterilization has summarized the studies on biological inheritance of dementia praecox as made previous to the publication of its own findings. It is quite obvious that the members of the committee accept the materialistic interpretation of man. It is in spite of this conviction, which created in their minds a strong presumption in favor of heredity as a possible cause of dementia praecox, that they make the following statements:

1. That there has been much criticism of the studies of inheritance of dementia praecox on which the report is based.
2. That such inheritance has not been demonstrated in a clear-cut, incontrovertible way.
3. That it is merely probable that "some" hereditary factor operates in the production of dementia.
4. That it is considered "only probable" that dementia praecox appears in certain families in a higher rate than in the general population.

Previously, Landman, in his summary of the studies available, concluded that medical science held dementia praecox, manic-depressive psychoses, and paranoia to be inheritable, but that the opinions were seriously disputed.

Pollock, Malzberg, and Fuller have presented new data on this subject of heredity, based on extensive studies of patients admitted to the Utica State Hospital from 1928 to 1930, inclusive, and have summarized the significant investigations previously made. These authors state that the opinion of psychiatrists, which has fluctuated considerably, at present favors the environmental and nonhereditary explanation of mental disorder. The trend is definitely toward seeking environmental factors, such as the trials of life, as an explanation of functional derangements. In concluding their scholarly work, these authors express the general view that family predisposition is of importance as an hereditary factor, but admit that science has not developed any exact demonstration of the inheritance of mental disorder.

Concerning the influence of heredity on the etiology of dementia praecox or schizophrenia, these same authors state:

Heredity must be regarded, however, as a generalized rather than a specific force. It is not believed that heredity will produce a case of dementia praecox spontaneously in a sense similar to that in which eye color appears with mechanical precision. The search has always been for releasing or inciting factors which are able to start the pathological mental processes which culminate in the disease. One set of investigators, who may be called organicists, look for such factors in the form of definite disease processes in the body. They find it impossible to conceive of such a disorder as dementia praecox other than as the result of an actual pathology of the body, and especially of the brain itself.¹¹

Physical Constitution

A variation of the hereditary explanation of schizophrenia is the specificity attached to bodily build as a cause. Pyknic personalities are said to tend to the manic-depressive disorders, and asthenic or leptic personalities to tend toward schizophrenia. Such physical constitutions would obviously be inherited.

The facts would seem to indicate that there is no scientific foundation for this opinion.

Definite relationships between physical constitution and certain mental disorders have often been hinted at by psychiatrists, but they have never been established.

Mere Circumstances or Occasions Are Not the Causes of Schizophrenia

Many contemporary psychiatrists claim that a whole array of factors produce schizophrenia. But all of these circumstances may be present or absent without in any way affecting the presence or absence of schizophrenia. They should, therefore, be called *occasions* rather than causes. Some clinicians find the cause of schizophrenia in such factors as age, sex, accident, reverses in fortune and economic status, failing health, war, debt, family bereavement, inability to succeed socially, etc.

Tredgold, discussing the etiology of schizophrenia, observes:

Some writers have attached considerable causal importance to such factors as overwork, pregnancy, childbirth, toxic or infectious illnesses, and the like. But, while the importance of these conditions as

determining factors may be admitted, I do not think that they ever, of themselves, cause schizophrenia in an inherently sound individual.¹²

Bleuler, likewise, speaking of the cause of schizophrenia, observes: Among the external conditions, pregnancy and more readily, confinement at times precipitate attacks of schizophrenia, also perhaps acute infections, but not more frequently than any psychic factor, especially an unfortunate love life. But we must assume that the disease is not engendered by such conditions but only made manifest.¹³

It is, therefore, imperative that we continually distinguish between the true causes of schizophrenia.

Disease as a Cause of Schizophrenia

Schizophrenia has been attributed to a whole group of diseases, among them being typhoid fever, scarlet fever, diphtheria, influenza, syphilis, meningitis, encephalitis, etc. In recent years special attention has been concentrated upon the possible reciprocal relations of tuberculosis and dementia praecox. This is due in part to the high death rate from tuberculosis among such patients, and in part to the fact that the tubercle bacillus has been found in the brains of some schizophrenics. It is clear, however, that the mere presence of the germ cannot be regarded as of causative significance in relation to dementia praecox, and it remains to be seen what results may be obtained by future research in this direction.

Bleuler on Schizophrenia

Because of its widespread belief, special comment on Bleuler's opinion on the etiology of schizophrenia seems indicated. His treatment of the etiology of schizophrenia is somewhat more complicated than the foregoing, and hence demands a more detailed treatment. The two main symptoms of schizophrenia, he says, are (1) disorders in affectivity, and (2) disorders in association.

The disorder in the affectivity is the tendency of the feelings to work independently of each other, instead of working together, which becomes evident, for instance, in ambivalence, in inadequate affective reactions, and many other observations which occur very frequently in schizophrenics. The associations, on the other hand, are no longer connected by a final aim and frequently deviate from the direction which is given in a normal person by the topic and by the aim of the central thoughts.¹⁴

This disorder in affectivity and in associations is caused, Bleuler teaches, by a previous splitting of the tissue, an organic defect which

results in the disintegration of the organic associations. On this point he agrees with the opinions already examined. The schizophrenic thinking seems to him to be of direct physical origin.

Conceptions and trains of thought often point clearly to brain pressure, and on autopsy, tense edema of the pia or brain swelling is found. . . . But in all chronic cases, too, decreases in the amount of ganglion cells and certain changes in the glia, furnish a proof that we are in the presence of a brain lesion, of course, not in the sense that the histological finding is the direct foundation of the primary psychic symptoms; it is merely an indicator of the existence of brain lesions, which, on the one hand, express themselves as psychic, and on the other hand as anatomical. Chronic histological findings always correspond with the clinical chronic picture, and acute changes, with acute ones.¹⁵

Schizophrenia is for Bleuler "a physical disease with a lingering course, which, however, can exacerbate irregularly, from some reason unknown to us, into sudden episodes and then get better again."¹⁶

In subscribing to the position that schizophrenia is a result of organic lesion, Bleuler is forced to go on to the point of maintaining that the whole pathological phenomenon occurs in spite of the person involved, entirely through the influence of the material degeneration suffered. "The fundamental disturbances, those of the thinking process and those of affectivity, develop quite independently of disagreeable experiences, from which not one of us is spared."¹⁷

And yet he must admit that in the life of the individual there is opposition or conflict between the demands of logic and reality on the one hand, and those of feelings, emotions, and complexes on the other. Yet, there is no causal connection between this conflict and the state of the schizophrène; the normal person, he says, that is, the person with normally functioning brain tissue, rapidly solves this conflict in favor of logic and reality.

The result of this preliminary organic lesion is that the thinking processes have become illogical and disintegrated, and the individual tends to follow the lead not of his intelligence but of his feelings and emotions.

Thus, with intelligence and logic gone, the individual has no unity in his life, no goal; he is not led by reason, but seeks solely the pleasure of the emotionally toned idea. Such a man lives by his complexes. He is split into as many personalities as he has complexes.

The schizophrenic ego is controlled now by this, now by that idea or complex. . . . So the patients, dependent upon their complexes, appear to be split into different personalities. . . . The schizophrenic has as many personalities as complexes—personalities which are more or less independent of each other.

The *over-all picture* of Bleuler's explanation of the etiology of schizophrenia includes the following premises:

1. Thought and brain tissue are coextensive.
2. Brain tissue becomes degenerated, dissociated, split; hence,
3. The thinking and emotional processes are dissociated and split.
4. The symptoms of such split are:
 - a) Disorders of affectivity.
 - b) Disorders in associations.
5. Conflict is found in the lives of all men. The thinking process, because of the tissue degeneration, the organic split, the looseness of logic, result in an exclusion of all associations opposing emotionally determined complexes.
6. The result is that henceforth the individual lives not according to reason but follows his emotionally toned ideas, his complexes; he practices autism or withdrawal from the unsatisfying real world into an imaginary one which offers more to the patient.
7. Henceforth, he is led now by one, now by another complex, and thus his personality is split into segments ruled by various complexes. This begets the split personality.
8. In the primary organic dissociation, ideas too suffer corresponding dissociation and are broken into fragments.
9. These partial ideas, these fragments of ideas, when combined form hallucinations and delusions.
10. The end result is a schizophrenia.

Criticism of the Causes of Schizophrenia as Advocated by Bleuler

1. Bleuler's psychiatric opinion is often accepted by those who maintain the existence of the soul, of mind, and of will. The reason for this attitude toward Bleuler's opinions probably arises because of his use of the words "mind" and "soul" in his psychiatry. But Bleuler, despite his partial retention of dualistic terminology, mind, emotions, ideas, and complexes, is a monist who in theory and practice denies soul, mind, and the freedom of the will.

2. Because he is an organicist, Bleuler assumes that thoughts, ideas,

and complexes are as extended as is brain tissue. However, as we have previously pointed out, it is established in psychology that such concepts as justice, pity, duty, kindness, right and wrong, good and bad, judgments and acts of reason as well as principles and ideas are totally devoid of extension. Thought is nonextended and immaterial. Ideas and judgments have no extension. Hence, Bleuler's opinion that ideas are coextensive with the material is incorrect.

3. The existence of organic or brain tissue dissociation or split required by Bleuler as the cause of schizophrenia is denied by scientists of note.

4. The presence of the organic or cerebral dissociation of splitting, even if it were present, could not account for any psychic processes or for any thinking, logical or illogical.

5. Dissociation as understood by Bleuler is an unacceptable concept as it supposes psychic as well as organic splitting.

6. According to Bleuler, schizophrenia is organically caused and is, therefore, entirely independent of man's will. But schizophrenia is a psychic phenomenon and cannot, therefore, be caused by dissociated, split tissue, or by anything material.

7. Bleuler errs, furthermore, when he claims that ideas may be broken into fragments and when recombined form delusions and hallucinations. Ideas are not extended and are therefore incapable of being split into parts. Psychologically a split idea is a contradiction in terms. Delusions, furthermore, are false judgments and are not produced from partial ideas.

8. The cure for schizophrenia as proposed by Bleuler consists largely of standing aside and waiting for organic conditions to be improved. This excludes the influence of education, and it also ignores the freedom of the will.

No Brain Pathology in Schizophrenia

All the scientific studies in this field indicate that there is no brain pathology in schizophrenia. At the present there is almost universal agreement that there is no known physical pathology for the disease.

Pollock, Malzberg, and Fuller state: "Present day psychiatrists are of the opinion that there is no definite pathology that can be adequately ascribed as being the cause of schizophrenia."¹⁸

Noyes quotes the French psychiatrist, Esquirol, as saying: "Pathology is silent concerning the seat of the madness."¹⁹

May says: "Notwithstanding the elaborate investigations of

Alzheimer, Silio, Kippel, Lhermitte, Meriyasu, Goldstein, Nissl and many others, no definite pathological basis for dementia praecox has ever been established." He concludes that the disorder is "without any definite organic basis which can be demonstrated at this time."²⁰

SOME BIOCHEMICAL AND PHYSIOLOGICAL ABNORMALITIES FOUND IN SCHIZOPHRENIA²¹

The major contributions made to this phase of the subject are interested not so much in etiology, but rather in "rounding out," as it were, the clinical picture of schizophrenia. Always an impetus to the investigation of the organic changes in this disease is the ever present desire to discover a "diagnostic test" for the entity. Diagnostic tests have reached such paramount importance in organic medicine that it was only natural the same should be sought for the identification and differentiation of the psychoses.

INORGANIC CONSTITUENTS IN THE BLOOD

Gross, *et al.*,²² in 1940, demonstrated a marked increase in the chloride content of red blood cells in schizophrenics. No increase in the chloride content of the blood plasma was noted. Possible "in vitro" changes were discounted as factors in this observation. Katzenelbogen and Snyder,²³ at a later date, found no variation in the serum chloride level but they did not investigate the red blood cells. Gross and his associates felt that the abnormal chemistry of the red cell indicated one is dealing with a disturbance of the whole organism and not with a localized brain disease. Further, they felt that acidosis and adrenal disturbances might be linked with the chloride changes noted.

Wikoff, Martin, and Marvin²⁴ have reported that the bromine content of schizophrenes' blood is consistently lower than the average values obtained for normals residing in the same area. Katzenelbogen, Haws, and Snyder²⁵ studied the oxygen and carbon dioxide content of arterial and venous blood going to and coming from the cranial vault in a small number of patients. They report that the oxygen content was decreased in certain cases, but no difference was found between the carbon dioxide content in patients and that in the controls.

ORGANIC ELEMENTS OF THE BLOOD: THE LIVER

Gildea, *et al.*,²⁶ noted abnormal values for nonprotein nitrogen, serum albumin, serum globulin, fatty acids, and cholesterol in a group of schizophrenics, manic depressives and unclassified psychotics.

Extraneous factors that might have accounted for the variations (dehydration, starvation, etc.) were carefully eliminated. The lipid (fatty acids and cholesterol) and serum protein values were found to be consistently below the lower limit of normal. It was interesting to note that with clinical improvement the serum proteins and lipoids returned to within normal limits in several cases.

Katzenelbogen, Haws, and Snyder²⁷ found a relatively low glucose blood level (arterial and venous) in certain of their schizophrenic patients. It was suggested that the relative hypoglycemia might cause a lowering of intracranial carbohydrate metabolism, the supposition being supported by findings of decreased intracranial oxygen content.

Evidence is at hand to suggest that hepatic insufficiency is associated with schizophrenia, to a greater or lesser degree. Quastel and Wales²⁸ reported that catatonic schizophrenics exhibited a definite disability to detoxify benzoic acid at a normal rate. This has been verified by Davies and Hughes.²⁹ However, the latter authors also showed that faulty detoxication, although far more readily demonstrated in catatonic states, was not specific for that group. As noted in the studies on proteins and lipoids, improvement in the liver's ability to detoxify benzoic acid paralleled clinical remission.

ANTI-INSULIN FACTOR

On the assumption that a disturbance in carbohydrate metabolism is an accompaniment and possibly a basic factor in schizophrenia, Meduna, *et al.*, have reported the presence of an "anti-insulin factor" in the blood of about 60 per cent of the patients studied. As a result of their findings a biologic classification for schizophrenia was attempted, but it could not be correlated with the accepted psychiatric classification.

However, Goldner and Ricketts,³⁰ in 1942, were not able to duplicate Meduna's results. Using the same experimental animals (rabbits), but another technique, they were not able to demonstrate an "anti-insulin factor." They attributed Meduna's results to varying degrees of insulin sensitivity in the test animals rather than to the presence of an "anti-insulin factor" in the blood of the patients.

PHYSIOLOGY

Angyal, *et al.*,³¹ reviewed the literature on the physiological aspects of schizophrenia in 1940 and pointed out that characteristic "hypo-reactivity" is found in three major fields:

1. Hyporeactivity to metabolic stimulants. The altered reactivity to medication with thyroid extract is cited.

2. Hyporeactivity of the autonomic nervous system.

3. Hyporeactivity of the central nervous system, reference being made to work done with vestibular and auditory stimuli.

These findings, together with the psychic elements involved, prompted the authors to suggest that schizophrenia is "psychobiologic" in origin.

Freeman investigated the abnormalities of the autonomic nervous system, particularly the sympathetic division. Using 20 chronic schizophrenics and 20 controls he studied skin and oral temperatures, oxygen consumption and evaporation of perspiration, both under basal conditions and following metabolic stimulation (using Dinitrophenol). His results showed that chronic schizophrenics exhibited less reactivity to metabolic stimulation than normal subjects.

Rosenbaum, *et al.*, studied intracranial blood flow in schizophrenia and concluded that the rate of flow in schizophrenia did not differ significantly from the normal.

Freeman, at an earlier date, had held that the schizophrène exhibited an abnormally slow and variable rate of peripheral blood flow. This, however, was later discounted by Gottlieb and by Abramson, *et al.* The latter group proved that most discrepancies were due to not controlling the circulation of the part used.

THE AKERFELDT TEST

Dr. Stig Akerfeldt of Stockholm has described a test applied to the serum of patients with mental disorders. He discovered that when he mixed 1.5 ml. of blood serum with an equal quantity of 0.1 per cent solution of N, N-dimethylparaphenyline hydrochloride, a color reaction due to oxidation occurred in sick people. The sicker the individual was, the more marked was the reaction which occurred. The test is far from specific for mental disease; in fact, it is most strongly positive in the blood serum of pregnant women. Although other clinicians have confirmed Akerfeldt's findings, its specificity has not been increased. It is not to be regarded as a specific test for schizophrenia.³²

THE SCHIZOPHRENE IS NOT AT ALL DETERIORATED

Schizophrenic patients are said to deteriorate. This statement should be carefully understood. The human body, since it is material, may

decay or may deteriorate, but not so the mind. The mind in thinking, reasoning, and willing depends on matter not as upon a cause, but only as upon a condition, as the eye depends on light for reading. The mind does the judging and reasoning. Mental incoherence, therefore, does not necessarily imply actual destruction of brain substance. The term "deterioration" as employed in schizophrenia signifies progressive inability of the individual to adjust to his environment. The deterioration of the schizophrenic denotes advanced social incompetence. He becomes so absorbed in images and complexes that he is unable to retain his hold on the world around him and ceases to function as a normal social being. This is due to psychological factors of thinking and not to deteriorated tissue.

THE SCHIZOPHRENE MAINTAINS ACCURATE SPECULATIVE KNOWLEDGE

The schizophrenic, if he can be induced to pay attention, displays excellent speculative knowledge. This may be observed in the intellectual processes connected with mathematics or languages. Even though he may be so engrossed in images as to display apathy and lethargy, once he is induced to apply himself he demonstrates the presence of unclouded speculative intelligence.

Many authors reach the same conclusion. The *Technical Manual* observes, "A negativistic subject will often surprise attendants and physicians by recalling occurrences that took place when, according to most competent observers, his withdrawal from reality seemed so absolute as to preclude the possibility of noting occurrences about him."³³ Tredgold agrees with the *Technical Manual* that the patients, on coming out of their stupor, can account for everything that happened while in that condition.

THE SCHIZOPHRENE USES WARPED INSIGHT OR PRACTICAL KNOWLEDGE

Insight is an activity of the practical intellect and manifests itself in the issuance of norms relative to the individual's conduct. Practical intellect, or conscience, therefore, indicates to a man what befits him as a rational being, what he ought to do, and what he ought to avoid. The practical intellect may exhort or impel the schizophrenic to perform duties which are decidedly unpleasant. But, preferring to follow the line of least resistance and pleasure, he ignores insight, his conscience, and avoids his obligations.

The schizophrenic is actually using insight, though warped and ineffective, when he regresses to creative imagination, to delusions and to hallucinations. Regression may help him forget his failures and partially escape their memory. The schizophrenic, in the realm of regression, seems practically to be an example of an individual with an invincibly erroneous conscience. He follows a false technique which he feelingly, emotionally, adverts to as true.

The young man of 20, who goes to college and depletes his widowed mother's slim savings to the extent of twelve to fifteen hundred dollars annually, and then wastes his time on athletic and social activities and does absolutely no studying during the entire year, and then, as a result, fails, displays poor insight. He himself, however, sees something good, commendable, pleasurable, or useful as the basis for his conduct. He is saving his energies, he claims, for the days ahead, or he is taking advantage of the social aspects of college life. In his crippled way of thinking, judging, and reasoning, he finds justification for his actions. To others, however, his actions seem stupid and absurd. He thus employs a very defective type of insight. The same irrational use of insight is displayed by men who indulge in drunkenness or in immorality. They hypnotize themselves by their own rationalization. In like manner, the schizophrenic sees something good in regression. It helps him to escape the taunts of his reason and perhaps his conscience and to avoid social failure.

DEVELOPMENT OF THE SCHIZOPHRENIC PERSONALITY

Schizophrenia Is Essentially Psychogenic

The development which culminates in schizophrenia begins in the early life of the individual. From his first years, the future schizophrenic is frequently unsuccessful in making happy, positive, successful contacts with the world that surrounds him. Because of this failure, the schizophrenic may very early develop strong feelings of inferiority which later begin to irradiate through all his thinking. The result is that he becomes timid, shy, bashful, perhaps anxious, apathetic, and withdrawn. He begins to daydream and to live in a world of fantasy. He becomes introspective and isolates his personality. He carefully avoids anything which demands a solution entailing toil, routine, or perseverance. On the other hand, he may become absorbed in books and be very successful in his studies. As the years pass, he becomes less aggressive and develops progressive timidity and pathological feelings

of inferiority. A sense of defeat insidiously creeps over him and he begins to appear inert and seems indifferent to success or failure.

This inertia and laissez-faire attitude is, however, not genuine. The potential schizophrenic is really unhappy. His intellect continually reminds him of his lack of realistic solution to his conflict. At a certain stage he may begin to realize from experience that some sort of solution to his problems, though inadequate and nonsatisfying, can be obtained by regressing from them, by ignoring their existence, or by imagining them solved.

The observer scarcely realizes how sensitive the schizophrenic may become. The sufferer may be aware of his inability to mix socially. He feels he is not one of the group, that because of his personality isolation and clumsy social techniques he is no longer welcomed or even accepted by his equals. He becomes more conscious of his plight. Life seems overwhelming to him. His basic aspirations are paralyzed and frustrated. He sees his urges, desires, and ambitions doomed to failure.

He is usually aware that his conflicts, problems, and disturbing situations can be solved. He is also aware that the solution depends largely on proper use of social technique, by personal effort, and by devotion to duty. But because of the schizophrenic's early philosophy of life, feelings of inadequacy, and inferiority, he seems unable to make the effort.

His higher critical power, the insight previously referred to, exhorts him to face the situation; it tells him that his failure is somehow his own fault, that he should exert more effort. This intellectual prodding of the practical mind, this consciousness of failure, is increasingly disconcerting to the schizophrenic; he accordingly does his utmost to avert his gaze from it and look in some more gratifying direction.

To assume psychotic symptoms would be for him less of an evil than to bear the taunts of his own conscience. Psychotic techniques become more desirable. In the regressed world of imagery he sees release and escape. Regression thus becomes for him the lesser of two evils. The farther into his regression he moves, the more he refuses to consider its evils: the fact that it is an unworthy solution, an inadequate escape, destructive of his personality.

In this realm of creative imagination into which the schizophrenic has regressed, a new and pleasant world opens to him. The practical intellect is ignored, reality is dodged, and ideas, judgments, and reason, which alone could have securely directed him, are abandoned.

In this world of fancy there is a strong feeling tone in the psychic life of the schizophrenic and he combines images into complexes and becomes engrossed in them. Reality at times almost ceases to exist for him, and images become invested with all the vividness of reality. There is autistic, catathymic thinking, and the schizophrenic begins to experience hallucinations and delusions.

This inner world of fancy gives the schizophrenic the opportunity of living and enjoying vicariously all his suppressed wishes and ambitions. His ego becomes inflated. He is a hero or a king; he builds air castles and lives in a paradise. The pauper becomes a millionaire in this land of images, and the social failure feels he is sought after.

The schizophrenic now lives, not according to true emotion, which is dependent upon intelligence, but by pseudoemotions, instincts, images, complexes, delusions, and hallucinations. It may be said that the feelings of the schizophrenic are in harmony with the operations of imagery, complexes and illusions. Though he becomes preoccupied with images and complexes and he fancies success, he nevertheless basically realizes all the while that he is being defeated by life itself.

In schizophrenia there are observable many more manifestations of regression than there are of dissociation. In this regression focal emphasis is placed on images, complexes, delusions, and hallucinations, while cold reality is relegated to marginal consciousness.

Schizophrenia is not a disease entity, transmitted from ancestors to descendants, but is a pathological regression to avoid realization of failure or to compensate for a sense of defeat in life. It is the reaction pattern produced by a maladjusted personality. It is caused by a false philosophy of life, by warped judgments, by undue attachment to feelings and images, by unregulated emotions. Schizophrenic symptoms result from compromises and truces made with feelings and emotions against the better judgment of the sufferer.

THE SCHIZOPHRENIC SYNDROME

The student should understand that in actual practice there are numerous variations in the clinical manifestations of the schizophrenic pattern. In various combinations and in differing degrees, the schizophrenic exhibits a great number of the symptoms.

When a cluster of seriously abnormal psychic symptoms appears against a background of emotional apathy and indifference resulting from systematic, habitual mental regression, the usual diagnosis is some type of schizophrenia.

SUMMARY OF SYMPTOMS OF SCHIZOPHRENIA

1. Pathological regression (introversion).
2. Substitution of images, daydreams, make-believe for reality.
3. Preoccupation, involved in images.
4. Prominence of pseudo-emotions (disharmony between mood and thought).
5. Surrender to life's problems.
6. Opposition to routine, lack of consistency, erratic.
7. Isolation of personality.
8. Good orientation frequently retained.
9. Well-preserved intellectual powers.
10. Presence of delusions and hallucinations.
11. Awareness of changed condition. Insight often acutely retained.
12. Disturbances of association.

The following case history is typical:

CASE 29: Schizophrenia

This patient was 18 years of age, single, a junior in high school at the time of the onset of the present illness. She was the third oldest in a family of six. The mother had always been high strung and "nervous." A maternal grandmother was a patient in a hospital with a diagnosis of senile psychosis. The patient's father was emotionally stable and owned a plumbing company in town. Even as a small child, the patient had been shy, reserved, and quiet. At the age of 12 she began to have moody spells in which she would withdraw from the family circle and stay by herself, talking with no one. She would then become overemotional for a short period of time. She had always been set and stubborn in her disposition.

One attack was said to have begun approximately two months before commitment, when the patient cried all day in school and refused to go home. She said she was ill, complained of her foot hurting, and when she reached her home later than usual that evening she refused to go to bed, ran out the back door, and later was found walking down the street, crying, saying she was going to become a nun, and was on her way to the priest's house. She threw herself on the grass, waving her hands about. When taken home, she talked in an obscene manner, thought her parents were abusing her, and told neighbors that her father was hurting her. She became overemotional and unmanageable. A nurse was called in and cared for her at home for four days, at which time the patient refused to

eat and could not sleep. She would frequently drop in a heap and wave her arms about. The family continued to care for her at home, although she could not return to her school classes. On the Fourth of July she went with the family for an outing, wandered away from the others, dressed only in her bathing suit, met two boys with whom she returned to her home, and announced she was going to have a good time with them. Until this time, the patient had never kept company with the opposite sex. When her parents intervened, she became violent, would not eat, jumped at her father, crying, "You see, I'm a leopard now." She clawed and scratched at him, although previously she had always been unusually fond of her father. A doctor was consulted, but she hid in a closet, refusing to see him. Physical examination revealed no abnormality.

Following insulin therapy, she showed a temporary improvement, but within two months again relapsed into her seclusive, disinterested, listless personality. She exhibited no ambition or initiative and was content to work at whatever required the least effort. Six months following insulin therapy the patient became slightly disturbed and exhibited the first marked fluctuation in mood since shortly after admission. She laughed and giggled a great deal of the time without apparent reason and was resistive to nursing care. This condition spontaneously cleared without specific treatment when she reverted to her former seclusive, shy, withdrawal attitude.

TYPES OF SCHIZOPHRENIA

There are *four types of schizophrenia*: (1) simple, (2) hebephrenic, (3) catatonic, (4) paranoic.

Simple Schizophrenia

1. Simple schizophrenia is described by the *Statistical Guide* as: (001-x21) "Cases to be classified under this heading show essentially defects of interest, with gradual development of an apathetic state, but without other strikingly peculiar symptoms and without expression of delusions or hallucinations."³⁴

2. *Symptoms.*

a) There are no definite psychic trends except regression, but this process ultimately affects the whole psychic life, the mind, the will, and the emotions.

b) Contact with reality becomes unpleasant. There is consequent lack of interest in work, games, and social life.

c) Apathy develops with loss of any competitive spirit which may have been present. Ambition for work is lost.

- d) Seclusiveness increases and the patient prefers to be alone with his images.
- e) The sense of responsibility decreases.
- f) An air of detachment develops as a result of which the patient frequently appears to be in a dream state.
- g) Ideas of reference and influence are common.
- h) Orientation is usually intact.
- i) Memory is good, but may appear defective because of lack of attention.
- j) The over-all picture is that of apathy, indifference, and lack of interest in the environment.

Hebephrenic Schizophrenia

This species of schizophrenia was first isolated by Hecker in 1871 and was included by Kraepelin under his term "dementia praecox" in 1899. Over half of the institutionalized patients with schizophrenia belong in this group. In addition to the general symptoms of schizophrenia these patients manifest great incoherence in their train of thought and speech, marked emotional disturbance, and superficiality. It has been appropriately called the "insanity of silliness."

Hebephrenia is described in the *Statistical Guide* as: (001-x22) "Hebephrenic type. Cases to be classified under this heading show prominently a tendency to silliness, smiling, laughter which appears inconsistent with the ideas expressed; peculiar, often bizarre ideas are expressed, neologisms or a coining of words or phrases not infrequently occur and hallucinations which appear pleasing to these individuals may be prominent."³⁵

Symptoms of hebephrenia.

1. The *onset* is usually about the time of puberty or early adolescence, and thus earlier than the catatonic or paranoid forms of schizophrenia. Hecker, who isolated hebephrenia in 1871, claimed that it appeared between the eighteenth and the twenty-second year. The tendency today is to look for its appearance earlier.
2. Hebephrenia usually begins as a result of profound emotional disturbance and it manifests itself in depression, gloom, sorrow, sadness. These complexes coalesce and thus form the basis for profound regression and psychic stagnation.
3. There is a characteristic schizophrenic apathy and indifference.
4. The personal appearance is neglected, the gait degenerates to a slouch, and the speech drawls.

5. After the depression, which varies in length, depending upon the individual, there follows pathological cheer, joy, excitement, and sense of well-being.

6. The excited mood may progress to euphoria. The patient may then display wild temper, may become intractable, may break furniture, tear clothes, or be assaultive.

7. At all times an element of gross immaturity, silly, incoherent speech, and irrational behavior is likely to be present.

8. Delusions and hallucinations are frequent and they account to a large degree for the irrational conduct.

9. Despite all this, orientation is fairly well preserved by the hebephrenic and there is little real clouding of consciousness.

10. Memory becomes hazy in proportion to the degree of regression achieved by the patient, but basically it is not affected. The same is true for the intellect. The hebephrenic has the power to think and reason, but prefers to follow his images and complexes. In that realm all his unfulfilled wishes are instantly satisfied.

11. Conduct becomes apparently aimless.

12. There is progressively less manifestation of the mental life and because of complexes there may be incoherence of thought and a display of poor judgment.

CASE 30: *Dementia Praecox, Hebephrenic Type*

The family history of this patient was noncontributory, except that the mother was high strung and nervous. The patient was an only child. Infancy was normal. She began school at 6 and in due time completed high school and normal school with an excellent record. As a child she was shy but had many friends. She was not a leader. Ordinarily she seemed congenial and happy, but manifested a "vicious temper" when crossed. Upon graduation from normal school she cared for her mother, who was ill and confined to the home, for about two years. She taught as a substitute teacher for several months. About this time the parents noticed a change in the patient. She became nervous and irritable. She developed a critical and fault-finding spirit toward her mother, whom she had previously adored. Medical examination disclosed that she was suffering from hyperthyroidism and operative measures were advised. However, the parents sent her to California for a rest and change in environment. On one occasion she suddenly became very agitated, screamed, and cried. Further medical advice was sought, and she underwent a pelvic operation for "cystic ovaries and retroversion of the uterus." Im-

mediately following this surgery she became acutely disturbed. She screamed, tore off her bandages, and became highly resistive. When she returned home, she grew gradually worse, lost interest in everything, could not concentrate, became extremely impulsive, talked in a rambling, incoherent manner, became extremely silly with apparently unmotivated laughter, and would frequently cry and scream. She refused food, was restless, agitated, and unmanageable so that she could no longer be cared for at home and was committed to a hospital. She continued to be resistive, negativistic, agitated, impulsive, destructive, and untidy. The following monologue illustrates her disordered stream of speech at this time. "When was I born? April 1, 1915. I have a pair of roller skates. We take exercise. I went in the front door and out the back. I took a bath, lady. I studied physiology. They taught me to eat lots of milk." To the accompaniment of silly giggling, she continues: "Lady with the white dress" (meaning the physician) "my grandfather was drowned in a well. So was my grandmother. I was vaccinated for smallpox. I had a blood test taken, lady!"

This psychosis in a young woman, age 26, developed suddenly and progressed rapidly. The marked changes in personality and disposition, mental confusion, poverty of thought, rambling and incoherent speech, memory defects, emotional deterioration, fleeting and changeable illusions, silliness, lack of insight and judgment, in addition to the other symptoms indicated above, warranted the diagnosis of dementia praecox, hebephrenic type.

Catatonic Type of Schizophrenia

Catatonic schizophrenia is characterized by stupor, excitement, or alternating states of stupor and excitement. Catatonia was first isolated by Kahlbaum in 1874. He described it as "a simple melancholia, or, as is the case frequently, as a melancholia with a subsequent mania, the melancholia atonita representing the third stage of the disease process." The melancholia atonita is what is usually known as waxy flexibility or *flexibilitas cerea*.

In 1913 Kraepelin further clarified Kahlbaum's analysis: "Under this designation (catatonia) Kahlbaum described a disease picture which in turn presents the symptoms of melancholia, mania and stupor, the unfavorable cases being accompanied by confusion and deterioration, and is furthermore characterized by the appearance of certain motor seizures and inhibitions, in other words, the catatonic disorder."⁸⁶

Catatonia usually appears between the ages of 15 and 25, and thus later than hebephrenia. Catatonia appears in an acute form in 40 per

cent of the cases, in the subacute form in about 40 per cent, and insidiously in the remaining 20 per cent.

The first appearance of catatonia is usually marked by deep depression, the presence of symptoms indicating the patient's recognition of defeat, disaster, and gloom. This melancholia affects the individual both physically and psychically. This melancholia at other times may remit, or be converted into, excitement.

Symptoms of catatonia

1. *Catatonic excitement*

- a) Excitement, when present, may resemble hypomania, acute or even hyperacute mania.
- b) These patients may shout, laugh, cry, break furniture, attempt suicide, or attack anyone.
- c) Excitement seems to be initiated by delusions and hallucinations.
- d) The excitement, however, is not strictly manic, because
 - 1) Catatonic activity is devoid of purpose while the manic-depressive motions always have some type of goal. The manic-depressive patient in his activity wishes to attain some object connected with pleasure or to avoid unpleasant situations.
 - 2) The catatonic patient answers questions irrationally; not so always the manic-depressive patient.
 - 3) The catatonic patient is basically placid and imperturbable while the manic patient is alert and highly distractible.

2. *Catatonic stupor or depression*

- a) There is so-called "waxy flexibility" and muscular tension.
- b) The patient may become negativistic.
- c) There may be complete stupor, inertia, mutism, and immobility.
- d) He may refuse to eat or pay any attention to his bodily needs.
- e) It should be noted that this stupor does not destroy awareness.
- f) Orientation for time, place, and person is usually retained.
- g) Remote memory is good.

CASE 31: *Schizophrenia, Catatonic Type*

This patient was a 21-year-old young man, single, who had had a high school education. His mother was said to have had a "nervous breakdown." The present illness began from one to two years prior to admission and was characterized by an unusual interest in religion, worry, and a refusal to eat. He would go into a corner for hours to

pray. The onset was gradual. Auditory hallucinations were in evidence, e.g., he thought he heard the Lord's voice. Speech was rambling and responses were delayed. He became unduly tense, consecrated all his waking hours to religion and to church activities. He spent most of the time praying and reading the Bible and expressed his life's desire of becoming a minister.

After the onset of his illness, his parents, despite his condition, allowed him to enter a college to study for the ministry. He was unable to concentrate on his studies, did not sleep, was slow in his classwork. He devoted all his time to "secret prayer." The dean of the college felt his influence detrimental to the other students and notified his parents of the patient's condition. He returned home and talked constantly about religion, expressed auditory hallucinations, and said he received messages from God. He was depressed and discouraged and spent hours writing religious tracts.

Prior to the onset of his present illness he had a good disposition, was cheerful, was never known to use profane words, and had no known bad habits. He was quiet, retiring, and serious-minded. He enjoyed swimming and out-of-door sports of a solitary nature. He kept company with the opposite sex and just prior to this illness became serious with one or two girls whom he met in his church work. On admission to the hospital, he was mild-mannered, quiet, and did not seem either depressed or elated. He was somewhat retarded in his responses. He did not associate with other patients, and when conversing spoke in a whisper. His sensorium was clear and fairly well preserved at the time of admission. Physical examination was negative.

Schizophrenia, Paranoid Type

The onset is usually acute with but few prodromal manifestations. The *age of onset* is later than in other types, the disturbance sometimes appearing suddenly before the age of 30, often as late as 45 years. It is more common among women.

This variation of schizophrenia is characterized by the presence of poorly organized delusions which may be fantastic, changeable, and grandiose. The paranoid type of schizophrenia is described in the *Statistical Guide* (001-x24) as: "These cases are characterized by prominence of delusions, particularly ideas of persecution or grandeur and frequently with a consistent emotional reaction of aggressiveness due to persecution. There may be hallucinations in various fields to which the patients react at first consistently but later, as deterioration occurs, apathy and indifference make an appearance."³⁷

Symptoms of paranoid type

1. The chief symptom is the presence of unsystematized delusions.
2. All other changes characteristic of schizophrenia may be present in varying degrees.
3. Hallucinations are especially frequent.

CASE 32: Schizophrenia, Paranoid Type

A young man, aged 27, was brought to the hospital. His family history was negative. He was the third child in a family of four. Birth and early childhood were normal. He began school at 7 and quit at 14, completing the first year of high school. At 23 years of age he entered a seminary. He remained there four years. About a month before commitment, one of the teachers notified his family that the patient was not normal and he was returned home. While at home he loafed about, could not apply himself to anything, whereas previously he had been an excellent student. He never drank, was single, never mingled with the opposite sex, and was always studious, very serious, and a shut-in type of person.

The present illness was thought to have begun two years before admission. Onset had been gradual and accompanied by a change in disposition. He became restless, suspicious, and evidenced persecutory delusions. He thought poison was being placed in his food and that his fellow students talked about and against him. He became irritable and accused the teachers of the seminary as partly to blame for his trouble. He said they accused him of being interested in some girl and that they repeated things about him which he had never done. He thought the movies were back of his trouble.

When the patient was first admitted to the hospital, he was restless, irritable, and quite resentful. He later became more friendly and co-operative and seemed willing to assist with ward work. He was tidy, ate well, and slept well. Mannerisms were present but not marked. There was a fair amount of interest in ward routine. Memory was intact, attention easily gained and held, no clouding of consciousness, and flow of thought was clear and coherent. Responses to questions were quick and relevant. He showed persecutory delusions and ideas of reference. There was marked disorder of judgment. He stated that he tasted abnormal substances in his food. Psychomotor activity was normal. He was correctly orientated. Insight was lacking. "I most certainly do not think there is anything wrong with my mind."

Six months following admission, the patient seemed to have shown some improvement in his condition and he was paroled to his mother. After one month at home, he left impulsively and went to live alone

in a shack in an isolated district. He lived strictly alone, allowing no visits from the family or friends, and got along in this hermitlike existence for nearly four years. He was then apprehended by the sheriff because he had threatened to kill a man who came unintentionally on to his place. He thought that neighbors were using some influence on him which generated electricity and that this message reached him by means of a voice. He thought this power could be harnessed, that it had four dimensions, and later it had two more, and a voice told him he should be the one to harness the power.

He was returned to the hospital. At first he wrote lengthy letters, frequently containing Latin phrases and sentences, addressed to various individuals, principally to movie actresses. He discontinued this practice, and three years later his condition seemed somewhat improved. He worked well, talked coherently, covered up his delusional content, and asked repeatedly for his release but made no attempt to escape. He read, attended amusements, and was one of the best ball players on the hospital baseball team. He wrote letters to his mother, stating his mind was improving and getting clearer. Suddenly, he lost all interest in baseball games and refused to participate in them, but would give no reason for his sudden cessation. He stopped attending amusements, would not attend church services, and took no interest in any activity. Three years later he denied hallucinations and delusions, but appeared to be covering up. He had ground parole, but walked by himself, never speaking to anyone. He was a dependable worker in the laundry. In two years he showed more deterioration, superficial insight into his condition, and still denied delusions of persecution. He talked to himself a good deal, remained tidy and neat in personal habits, but responded only with a curt "yes" or "no" to questions. He appeared somewhat retarded.

In 1940 he suddenly complained of a sharp pain in the abdomen which doubled him up. Examination revealed a perforated peptic ulcer, for which he was operated upon. During the postoperative course he developed an unresolved pneumonia from which he recovered slowly. He made no physical complaints and was agreeable and co-operative during his illness. He was returned to the ward, where he adjusted much as before.

Four years later, he denied all delusions as well as hallucinations, although apparently constantly reacting to the latter. His speech was relevant but circumstantial. When not working, he sat with his head down and took no interest in any interview. Memory seemed good and calculation was good. A year later he showed further evidence of mental deterioration, was indifferent to his surroundings, would talk on no subject other than his ulcer operation and, aside

from this topic, conversation was irrelevant and confusion quite evident. He was quiet and orderly and worked around the hospital, still retaining his ground parole. One day it was noted that the patient, always inconspicuous in his behavior, seemed to have lost considerable weight. Chest X-ray revealed active, far advanced pulmonary tuberculosis, although the patient had made no physical complaints. He was transferred to the tuberculosis ward and died within two weeks. At the time of death, his mental condition had shown gradual, progressive deterioration over a period of twenty years.

PROGNOSIS

Formerly, schizophrenia was considered incurable. The outlook is now somewhat more hopeful. Remissions and even cures are possible, but disorders of this nature are always considered serious. Complete cures in the sense of total restoration to normalcy are rare indeed. Some psychic defects generally remain; the personality is somewhat affected. In cases of chronic schizophrenia, i.e., where the psychotic onset represents the culmination of old, deep-seated mental habits and character traits, the outlook is poor. If the onset is acute and has not been preceded by long psychotic indulgence in undesirable reactions, the outlook is better. It is said that about one fourth of schizophrenic patients recover sufficiently to return to society. About 50 per cent require short periods of hospitalization. Twenty-five per cent are permanently hospitalized.

Some cases that have been classed as schizophrenes are episodic. Remissions do occur; sometimes satisfactory social rehabilitation takes place.

In any case, certain prognosis is impossible; the outcome and course of the disorder is uncertain. Each case must be judged on its own merits.

The prognosis of simple schizophrenia is poor; the hope for ultimate recovery from paranoid schizophrenia is not good; there may be remissions for the catatonic variety; for the hebephrenic type prognosis is unfavorable.

TREATMENT

Therapeutic measures with schizophrenic patients should be based on the general principle that the schizophrenic reaction is psychological rather than biological. Careful attention must be given, it is true, to the physical needs of the patient which may be as varied in nature and different in intensity as the ills of normal people.

Investigation and careful study of the prepsychotic personality and the incubation period of the psychosis will be a tremendous help to the therapist. No two cases will be alike. Individualized treatment is a necessary requisite of success.

Psychotherapy is more important, though more difficult than physiotherapy. Even when conditions indicate the advisability of the latter, psychotherapy is always important. Without it, physiotherapy may be useless. Prolonged narcosis is no longer considered advisable.

Insulin shock treatment has been widely employed. The future of this type of treatment is uncertain. The same may be said of metrazol shock and electroshock treatment (q.v.). Prefrontal leucotomy (q.v.) is a radical operation that should only be employed as a last resort. Its status as a desirable therapy is also problematical.

PROPHYLAXIS OF SCHIZOPHRENIA

The following suggestions have special application to the prophylaxis of schizophrenia:

1. Parents and teachers can do much to prevent schizophrenia by early orientating the child toward a realistic goal.
2. The child needs a sound philosophy of life from the very start.
3. As soon as possible some responsibility should be placed on the child. For this accomplishment he should be gently but firmly held accountable.
4. The realistic approach should be made pleasant from the very beginning by suitable reward and praise.
5. The child should not be made to feel embarrassed if he fails. He should be helped to achieve success as soon as possible.
6. He should be taught that there are no short cuts to success and no substitute for hard work and diligence.
7. The child should be socialized from his earliest years.
8. He should be required to compete in studies and games within the limits of his ability.
9. He should learn to be a good loser and not to become easily despondent. He should be advised to treat reverses as stimuli toward increased activity rather than as causes for regression.
10. Character formation based on high ideals and self-control is important.

WHEN DEALING WITH PATIENTS WHO HAVE ALREADY SUFFERED SCHIZOPHRENIC EPISODES, THE FOLLOWING SHOULD BE BORNE IN MIND

1. Schizophrenia is basically a disorder characterized by regression from intellect to levels of instinct, memory, imagination, feelings, emotions, and complexes.
2. Schizophrenic regression occurs because of the desire to avoid realistic situations or to compensate for real or imagined frustration.
3. The point of view of avoidance or of compensation supplies the psychic machinery for the schizophrenic and explains why he wishes to remain with his images and complexes. Regression is for him something good and acceptable or at least the lesser of two evils.
4. The schizophrenic will remain in his world of images and complexes so long as he finds them more pleasant than he does the world of reality.
5. It is most important to search for the basic factor around which the patient has developed his complexes.
6. The time may arrive when the patient will profit by the explanation of the nature and reasons for his complexes, delusions, and regression.
7. The value of returning to the world of reality should be stressed. More by instruction than by argumentation, attempts should be made to facilitate his return to reality. Indicate to the schizophrenic the value of an intellectually honest approach to life and to his problems.
8. The valuable psychological therapies of suggestion, encouragements, and re-education should be employed as much as possible. For the schizophrenic, re-education is the most difficult but by far the most effective method to be used in restoring him to reality.
9. All should realize that the process of recovery will be slow and will require much tact and patience.

INSULIN SHOCK

In 1933, Manfred Sakel of Vienna introduced insulin therapy for schizophrenia. It was at first received with great enthusiasm, but as its difficulties and dangers became more apparent, its popularity decreased. In proper hands and for suitable patients it undoubtedly has value. There are no satisfactory theories for the mechanism of its action. It undoubtedly affects the metabolism of the brain cells and there has been noted a decrease of potassium in the cell structure and an anoxia.

The treatment, which cannot well be standardized and must be varied from one patient to another, consists of giving gradually increasing doses of insulin until the patient goes into a stupor or coma from 1½ to 2 hours daily. During this period the blood sugar usually goes as low as 28 mg. per 100 cc. The average daily dose of insulin to produce a coma is between 250 and 300 units of regular insulin. After the patient has been in a coma for the desired period, the blood sugar is restored to normal readily by the intravenous administration of glucose. The treatment is usually continued for 60 or 70 reactions.

In some clinics, if no improvement occurs in 50 treatments, metrazol or electroshock is given while the patient is in the stupor. This combined treatment is given every other day for about twenty days.

In 1954 Dr. Sakel published an extensive reappraisal of the classical Sakel Shock Treatment. In spite of his eloquent plea, insulin shock treatment is being used less frequently. Whether this is due to a widespread opinion that it is too risky for the slight help which it offers, or due to the widespread use of tranquilizing drugs (see p. 295), is difficult to say.³⁸

SUBSHOCK INSULIN THERAPY

A modification of the insulin shock therapy has come into vogue during recent years. This is subshock insulin therapy. It has considerable value in the treatment of schizoid conditions. Insulin is given in gradually increasing doses until an insulin reaction is produced twice daily. For this purpose the insulin is given about two hours before the noon and evening meal and the ingestion of the meals serves to terminate the reaction. The increase in the insulin dosage is stopped when reactions begin to occur. No attempt is made to produce coma. This treatment is continued for about six to twelve weeks.

A recent variation of this treatment consists of giving a single daily dose of regular insulin at eight o'clock in the morning. Breakfast is omitted and the reaction is terminated by lunch. This method produces reactions more regularly and of a more similar pattern. It is to be preferred to the method described above.

ELECTROSHOCK THERAPY

For a description of this procedure, see page 388.

SUMMARY

The schizophrenias are the most common of the psychoses constituting from 15 to 20 per cent of patients admitted yearly to mental institutions. At present the terms "schizophrenia" and "dementia praecox" are used as synonyms. These disorders are psychogenic disorders, the principal mechanism employed being that of pathological regression. Although a great deal of work has been done to prove the biological origin of schizophrenia no real evidence has been produced. As we have indicated in the text, most studies have revealed physical changes which were inconstant, or unconfirmed by other workers, or merely concomitant and not causal. The treatment of the schizophrenia is frequently unsuccessful. The most effective measures are prolonged hospitalization, psychotherapy, insulin shock therapy, and electroshock therapy.

FOOTNOTES

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THE MANIC-DEPRESSIVE PSYCHOSES

DEFINITION

The manic-depressive disorders are a group of psychoses of psychogenic origin which do not terminate in mental deterioration and are characterized by emotional extremes of excitement or depression and by a tendency to recurrence.

There are six elements in the definition of manic-depressive psychoses, and each will be discussed in turn.

1. *Manic-depressive psychoses constitute a group of disorders.* The manic-depressive psychoses manifest themselves not in any one static type of reaction, but present a variety of fluctuating, changing patterns.

2. *Manic-depressive disorders are true psychoses.* Manic-depressive psychoses are serious mental aberrations.

3. *Manic-depressive psychoses are of psychogenic origin.* They are caused, not by somatic disease nor by toxic conditions, but are patterns of reaction to unacceptable environmental situations or to ill-solved conflicts. Manic-depressive psychoses are begotten through the influence of ill-regulated mental operations and emotions.

4. *Manic-depressive psychoses do not terminate in mental deterioration.* In manic-depressive psychoses, there is obviously great mental impairment. Yet in the manic-depressive psychotics the diminution or suspension of intellectual activity, though grave, is not permanent. The emotional excesses are likewise transient. Excessive elation or depression disappear and the intellectual life of the patient emerges intact. Despite the inroads of manic-depressive psychoses on the personality, real mental deterioration never occurs. This is apparent from the conduct of patients upon recovery from the disorder. One may observe numerous cases in which manic-depressive psychotics have their mental powers restored to complete normalcy.

5. *Manic-depressive psychoses are characterized by emotional excitement or depression.* Moderate mood swings and emotional ups and downs are characteristic of all people. But when such reactions are partly or entirely unjustified by objective circumstances and become incompatible with normal existence or with required social-economic

status, they become pathological. The outstanding characteristics of the manic-depressive disorder are the simple or combined forms of excessive *mania or emotional elation, and excessive emotional depression*.

Manic or elated phase of manic-depressive psychoses, as is evident from the name, is characterized by all or many of the manifestations of euphoria or pathological good feeling. While in the manic condition the patient is expansive, active, rapid of speech and gait, apparently happy, unduly optimistic, and too full of good humor.

The *depressive reaction* in manic-depressive psychoses is the direct opposite in its characteristics. Patients so affected are sad, melancholic, and apparently weighed down with many subjective and imaginary troubles. They are retarded in activity, pessimistic, and despondent in mood.

More or less exaggerated extremes of elation and depression or undesirable and unhealthy emphasis of either state is often noted in neurotic conditions. Variations of the so-called manic-depressive syndrome are also noted in cases of feeble-mindedness, epilepsy, organic, and toxic psychic disorders.

6. "*And by a tendency to recurrence.*" Many cases of manic-depressive psychoses improve. Some patients are cured and sent home. In some of these cases the disorder reappears.

HISTORICAL BACKGROUND OF THE MANIC-DEPRESSIVE PSYCHOSES

In the literature on this disorder we encounter detailed descriptions of over fifty types of mania or elation and about twenty varieties of depression. Until recently, mania or elation was isolated and treated as a distinct disease entity. Mania was supposed to be autonomous and to possess its own syndrome, course, and outcome.

Melancholia or depression was likewise isolated and described as a separate entity with no obvious relation to mania or elation. Scarcely any author thought of combining the seemingly contradictory elements of mania and melancholia or of making them constitutive elements of one mental disorder.

About one hundred years ago, Falret, Sr., and Baillarger, working separately, observed the successive occurrence of mania and melancholia in the same persons. This indicated a possibility that there might be some connection between the two disorders. Their investigation did not produce any tangible results. It gave the impulse, however, to others for further study.

In 1879, Falret, Jr., discussed what today in psychiatry may be called "circular insanity." In this variation, the manic phase was followed by melancholia, and melancholia was followed by mania without any lucid, quiescent period in between.

Falret, Jr., also looked upon the mixed state of manic-depressive psychoses as an intermediary between the manic and melancholic attacks.

In 1882, Kraepelin¹ expressed the opinion that manic-depressive psychoses consisted of either elation or depression. Under the term "manic-depressive psychoses," Kraepelin included periodic and circular insanity, mania, melancholia, some cases of confusion and some of delirium. He also regarded these disorders as symptoms of an underlying somatic disturbance, heredity, and defective organism.

Mania, Kraepelin observed, might lead to melancholia; melancholia might in turn lead to mania. He also taught the recurrent nature of the manic-depressive psychoses. Finally, he observed that the disorder did not result in deterioration of the personality. The only deterioration present, if there was any at all, was a lack of the psychic, intellectual, and emotional depth, a laissez-faire approach to life, a lack of drive, an undue tendency to distrust one's own judgment, and a proportionately increased tendency to be led by others.

Because of the frequent occurrence in the same individual of excitement and depression, mania and melancholia, Kraepelin called the disorder manic-depressive psychosis. This nomenclature is still accepted.

ETIOLOGY

Age of Onset

It is generally held that about 60 per cent of those who become manic-depressive psychotics manifest the symptoms between the ages of 15 and 25; in 30 per cent of the cases the onset is between the ages of 26 and 40; in about 10 per cent it appears after the age of 40.

Kraines² asserts that the peak age of incidence is between the ages of 35 and 40. Strecker³ says that female patients are affected most between the fortieth year and fiftieth year. The average age for men is somewhat later. Pollock, Malzberg, and Fuller set the age of incidence at 42.1 for women and 38.9 for men. According to them, the onset of the manic-depressive psychoses coincided with the periods of great emotional or psychic strain. It is estimated that two thirds of the attacks occur in women.

Incidence

About 15 per cent of all admissions to mental hospitals are manic-depressive psychotics. Many claim that another 25 per cent of patients suffering from this derangement never reach mental hospitals. Of 70,987 first admissions to 48 mental hospitals in 16 states, there were 12,512 manic-depressive, or a trifle over 15 per cent. About 8000 new cases are admitted to public mental hospitals yearly. Kraepelin⁴ reported that from 10 to 15 per cent of those who entered his clinic were affected by manic-depressive psychoses.

The type incidence is as follows:

<i>Type</i>	<i>Percentage</i>
Manic	45 per cent
Depressive	39 per cent
Mixed	11 per cent
Circular	03 per cent

Heredity

Some students are of the opinion that manic-depressive psychoses are caused by hereditary transmission. As pointed out in Chapter XI we find little evidence to support this opinion. In agreement with this viewpoint is the position presented by Pollock, Malzberg, and Fuller:

However, the observed frequencies of manic-depressive psychoses in the several generations cannot be explained adequately on the basis of known biological laws. . . . Heredity cannot be a complete answer to the question of the origin of a mental disorder. The onset of the disease is not a physiological phenomenon with a subsequently determinate course at specific periods in life. There is no fatality associated with the transmission of mental disease such that an individual with a heavily tainted ancestry must necessarily develop a mental disorder.⁵

Pyknic Body Build

One particular version of the hereditary explanation of psychoses is used by some contemporary psychiatrists to account for the presence of the manic-depressive disorders. They maintain that this type of mental disturbance is causally related to the *pyknic body build*.

The "Outline of Neuropsychiatry in Aviation Medicine" states: "There seems to be a clear biological affinity between the psychic disposition of the manic-depressive and the pyknic body type."⁶

Endocrine Imbalance, Tissue Degeneration, or Organic Lesion

Many psychiatrists have assigned endocrine imbalance, physiologic change, tissue degeneration, and organic lesion as causes of manic-depressive psychoses. Endocrine imbalance, tissue degeneration, and organic lesion, according to one popular assumption, owe their origin to an inherited lack of durability of the brain cells or cerebral tissue. These opinions are but variants of the widely accepted but highly questionable dogma of the hereditary transmission of manic-depressive psychoses.

Dualistic Approach to the Etiology of Manic-Depressive Psychoses

Since the organic explanation of the etiology of the manic-depressive state is obviously and admittedly inadequate, we will follow the lead indicated by Pollock, Malzberg, and Fuller, and search elsewhere for a sufficient explanation of its cause: "In the absence of any knowledge of a specific pathology in connection with the causation of the manic-depressive psychoses, we must examine the environmental history of the patient in order to discover precipitating factors." These authors outline psychogenic factors which if incorrectly resolved may lead to the manic-depressive psychosis. Some of these factors fall into the following categories: (1) death of a close friend or relative, (2) loss of position or employment, (3) financial loss, (4) disappointment in love, (5) frustrations in pursuit of a goal, (6) loss of social esteem, and (7) exposure to danger.

These events and situations are of significance only as they arouse emotions of anxiety, sorrow, fear, hatred, or other mental conflicts. At times, the connection between cause and effect in these situations is very close; at other times, the onset of mental disease may be deferred for a considerable period; the greater the lapse of time, the less certain the causal relation.

Psychogenic Origin of Manic-Depressive Psychoses

Widespread clinical experience of practitioners confirms the contention that the causes of manic-depressive psychoses are psychogenic. There is a growing tendency among psychiatrists to consider the manic-depressive psychoses as defective reactions to stresses and strains of life's adjustments.

Dorcus and Shaffer, when defining manic-depressive psychosis, stress first the emotional, affective, or psychogenic origin of the disorder and,

second, the appearance of elation or excitement on the one hand, and depression or melancholia on the other.

The manic-depressive psychoses constitute a group of mental disorders characterized by conditions which are the opposite of each other, elation and depression. . . . The manic-depressive psychosis is classified as a functional one and the origin is, therefore, said to be psychogenic.⁸

Lichtenstein and Small stress the psychogenic as opposed to hereditary causation of manic-depressive psychoses.

Life situations are important as precipitating factors. It is rare to see a mood disorder that has occurred automatically. Significant dynamic factors almost inevitably play a role. The mental problems act as a releasing force for emotional stresses arising from disturbed family relations, sickness or death in the family, financial or sexual difficulties. Experiences that may appear to be trivial to the objective observer may have great meaning for the person in whom they have revived conflicts or tendencies experienced in childhood.⁹

The authors of *Technical Manual* observe:

The increasing belief is that heredity has been overemphasized. The reason for this is that terms have been applied loosely, as have statistics. . . . The present day opinion is that improper early mental hygiene or improper guidance is the cause of many of the psychological problems that were generally held to be of hereditary origin.¹⁰

The same authors discussing the etiology of the manic-depressive psychoses remark:

There is a personality make-up of irritability and instability with proneness to excitements and depressions without adequate cause. On such a predisposing background, any exciting factor, one perhaps not unduly disturbing to the normal individual, is sufficient to produce psychotic disturbance.¹¹

Strecker, an outstanding contemporary psychiatrist, thinks that these patients have developed a false pattern of thought and are using defective mental mechanisms. He further says that there is no need to go beyond the everyday activity of the patient to explain the origin of a psychosis. The patient compensates for acknowledged failure. Hence, it seems that a psychogenic cause for the manic-depressive psychoses must be granted. Interpreting the background and etiology of manic-depressive psychoses, he writes:

I have been impressed by the frequency of cases in which the manic phase appears to be a compensation for the innate and environmental inferiorities of everyday living. In itself, the manic phase is a declaration of individual power and dominance. In the display of emotional thought and motor activities, not only does the patient demonstrate that his inhibitions are in abeyance, but he attempts to brush aside with scornful aggressiveness and violence the slightest opposition from the environment. Concretely, one often sees a particular compensation for a belittlement and humiliation of previous life.¹²

The above authors and many others take issue with the materialistic approach to the etiology of manic-depressive psychoses.

CLASSIFICATION OF MANIC-DEPRESSIVE PSYCHOSES

The following classification of the manic-depressive psychoses shows clearly its great variety of manifestations:

- | | |
|--------------------------|--------------------------|
| 1. <i>Manic type</i> | b) Acute repression |
| a) Hypomania | c) Stuporous depression |
| b) Acute mania | 3. <i>Circular type</i> |
| c) Hyperacute mania | 4. <i>Mixed type</i> |
| 2. <i>Depressed type</i> | 5. <i>Perplexed type</i> |
| a) Simple retardation | |

The boundaries between these types are not fixed or clear. Different degrees of mania and depression do exist. Manic-depressive psychoses may begin at any point in the upward or downward course of the disorder. Some patients, who are hypomanic, may not progress beyond that phase. Others give first indications of manic-depressive psychoses by displaying the acute manic phases with the symptoms of hyperacute or delirious mania.

GENERAL SYMPTOMS OF MANIC-DEPRESSIVE PSYCHOSES (MANIC PHASE)

The manic phase of manic-depressive psychoses is described in the *Statistical Guide* as follows: "Manic type with elevation of spirits (elation) or irritability, with overtalkativeness or flight of ideas and increased motor activity. Transitory, often momentary, swings to depression may occur but should not change the classification from the predominantly manic type of reaction."¹³

The following symptoms in varying degrees of intensity are common to the manic phases of the manic-depressive psychoses:

1. *Flight of ideas*: The patient's flow of ideas is much disturbed.

He is so easily distracted that he tends to ramble freely and incoherently. He is extremely distractible and rarely reaches a conclusion.

2. *Emotional excitement.*
3. *Rapidity and incoherence of speech.*
4. *Rapidity of action.*
5. *Relative harmony of thought, emotion, and action.*

MANIC TYPE, HYPOMANIA

The hypomaniac is well orientated, may hold a good position, and if he does not go beyond the hypomanic phase, may in the early period of the disorder even impress the public with his initiative and drive. At the hypomanic phase of the manic disorder, there may be transient hallucinations or delusions. The emotions are strong and certain complexes, especially those of superiority which may be merely compensations for failure and defeat, are frequently present. Mind, imagination, and all psychic powers function so rapidly as to affect the entire physical organism. Images and emotions stimulate the individual and beget excitement. The mind is quick, emotions are strong though fleeting, feelings are clamorous, the physiological as well as psychic equilibrium of the patient is upset. All in all, however, there is no mental deterioration or basic lack of power to think, reason, and judge.

Symptoms

1. Inability to concentrate.
2. Excitability of manner.
3. Inability to achieve anything significant despite disproportionate output of energy.
4. Gives impression of compensation for acknowledged defeat or failure or for inadequate solution of a conflict.
5. Unity of psychic powers — thought, emotions, feelings, action.
6. Transient delusions or hallucinations.
7. Insight is quite defective.

CASE 33: *Hypomania*

A married woman, aged 35, was admitted to the hospital suffering from mild manic excitement. She had been apparently normal until two years before her commitment. At that time she experienced a feeling of fatigue, depression, and inability to "pull herself together." After moving to another town she developed a "nervous condition" and began to worry extremely. She went to a general hospital for a rest but, upon returning home and for six weeks previous to her

admission to the hospital, she had become erratic in her behavior. She was overtalkative and felt that people were watching her and talking about her. She asked many friends if they thought she was going insane. She told her husband she was in love with another man, but later denied it. About this time while the patient and her husband were visiting friends, she noticed a rash upon her back. Immediately she felt that she had become infected from an article of clothing belonging to this friend. She then went to a lawyer and told him that she had evidence against her friends. Her behavior continued to be unpredictable and erratic until it was decided to bring her to the hospital for observation. She admitted that she had entertained suicidal thoughts, but had never made an actual attempt.

In the hospital she was slightly expansive and euphoric. When walking about the day hall, she swept through majestically with a blanket wrapped around her lower body and with a secretive and haughty look on her face. Her answers to questions were sometimes silly, often sarcastic, most of the time with a hidden or double meaning and sometimes with no meaning at all. She had ideas of grandeur, an exaggerated sense of her own importance and capabilities, and she talked volubly. She was well oriented, had little insight, believed that her home conditions made her rundown and nervous, but that there was nothing seriously wrong with her. "What I need is diet, fresh air, sunshine, exercise, and carrots," she said.

Physical examination revealed no pathology in any of the systems.

MANIC TYPE, ACUTE MANIA

Acute mania is that phase of the manic-depressive psychosis in which the most serious aspects of the disorder begin to assert themselves. The patient has the general symptoms of mania already discussed. The acute manic has the flight of ideas, emotional excitement, rapidity of action and of speech which characterize the manic phase of the manic-depressive psychoses in general. Proper to itself, however, acute mania has the following:

1. *Hyperprosexia*, or *disordered attention*. "In this condition, the attention of the patient is completely absorbed by certain thoughts, usually his delusions. The absorption may be so complete that no attention whatever is paid to the environment. Perception would, of course, be very inadequate."¹⁴

The inattention occurs because the patient is so stimulated by his images and their irrational combinations that he does not fully attend to environmental stimuli. In acute mania, the patient's complexes of success and well-being are so vivid, so emotionally fervid, and so en-

grossing that external stimuli are unable to compete for a hearing. Such combinations of complexes produce disorientation.

2. Distractibility with more pronounced judging and reasoning.
3. Almost no sequence in thinking, judging, and reasoning.
4. Psychic exaltation, inflation of the ego, euphoria.
5. Grandiose, though unsystematized, delusions.
6. Transient hallucinations of hearing and vision.
7. Harmony between thought, emotional reactions, and actions.
8. There may be boisterousness, shouting, irrational laughter, increased speed in thought, word, and deed.
9. Destructiveness, breaking of furniture, windows, and destruction of bedclothes is common.
10. The patient does not seem to be exhausted, though he takes little food or drink.

MANIC DEPRESSIVE PSYCHOSIS, MANIC PHASE

CASE 34: *Acute Mania*

A 16-year-old boy was brought to the hospital by his parents because of unusual behavior. The boy's early history was not significant. He was the youngest child of a large family and his parents were goodhearted but not very understanding. He had always done extremely well in school and was very fond of music. He had never been a behavior problem and had caused the family less worry than any of the other children. He was always active and interested in things and never showed any tendency toward daydreaming or solitary activities.

During the previous winter, he had become increasingly active. He was in his last year of high school, since he had taken more than the usual course throughout. He had begun to talk of college. He had written to dozens of schools, obtaining information, and had talked volubly about all the things he wanted to do, settling on a different professional career almost every day. He then suddenly dropped the idea of college and talked about taking up flying and this had occupied his attention for some weeks.

About a month before admission he told his mother that he was sure that he was sick, and asked her to take his pulse. Because he showed no evidence of physical illness, his family laughed at him. Without any further warning, he disappeared from home one night. He was found the next day in a town some miles away and said he had slept in a tree all night. When he was brought to the parents' home he was very overactive, would start to say or do something but would never complete it. He began to lose all interest in his personal ap-

pearance, refusing to wash and change his clothes. He began to develop peculiar actions, strutting about and declaring he was Hitler and Mussolini, and imitating various characters in the comics.

After two weeks of this behavior, he suddenly cleared up and became apparently normal for a period of two weeks. He then had a recurrence of his previous behavior and was brought to the hospital. His activity there was constant. He talked continually, showing a very marked flight of ideas and distractibility. He was so lithe that it was difficult to restrain him, and he took large doses of sedative without any visible effect. He would appear to be thoroughly restrained and at rest, but after a few minutes he would be found out of bed, the bed stripped and the clothes scattered all about the room. On one occasion he completely took the bed apart, even removing the coils and bedsprings. He was always cheerful and would willingly do what he was asked, only to assume his old behavior again in a moment. He refused to keep anything on him and was naked most of the time.

During a period of four weeks, he showed occasional days of improvement, followed again by recurrence of the manic behavior. For financial reasons, his family took him to a state hospital where he entirely recovered during the next two months and was discharged.

This youngster is an example of a typical manic attack with the usual recovery. His future course may be characterized by other attacks, but his prospective recovery from each one is good. He may also, of course, manifest depressed phases of the condition at some future time.

MANIC TYPE, HYPERACUTE MANIA

The *hyperacute mania* is often called *delirious mania*. In this phase we find the usual symptoms of the manic-depressive psychosis, e.g., flight of ideas, emotional excitement, rapid and incoherent speech, rapidity of action, harmony between thought, action, and emotion. All of these symptoms appear in a pronounced degree in the hyperacute phase of the manic-depressive psychoses. Proper to hyperacute mania are the following symptoms:

1. Wild flights of ideas, images, emotions, and feelings.
2. Marked delusions, though these are not as systematized as are those found in the depressed phase in schizophrenia and in paranoia. The delusions are usually grandiose and merely reinforce those that were found in the acute phase.
3. There may be hallucinations, though somewhat transitory and of an auditory and visual nature.

4. There is almost complete disorientation. In this condition the clouding of consciousness is more severe than in the acute mania.
5. There is noticeable excitement, which so absorbs the patient as to make him forgetful of eating, sleeping, or exercise.
6. There is total lack of insight.

CASE 35: Manic-Depressive Psychosis, Hyperacute Mania

A white, single male, aged 48, was brought to the hospital in a state of delirious psychomotor activity. His first attack had taken place some three weeks before admission. The onset was rapid and all manic symptoms quickly increased in intensity. He was completely out of contact with his environment. He refused food or water and resisted all nursing care. There was uninterrupted jerking movement of all his extremities and continuous motor unrest. According to the history, this state had been preceded by depression, apprehension, and refusal to talk.

Upon entering the hospital, he gave his name and then spoke no more, though he moaned and groaned constantly.

The patient died six days following admission. The cause of death was exhaustion resulting from hyperacute mania.

MANIC-DEPRESSIVE PSYCHOSIS, DEPRESSED PHASES

Depression, as well as mania, is of great psychiatric interest. Mania often arises from depression. Depression usually has its origin in the realization of defeat or failure in life. It often begins, too, in mania and in some respects is the grave to which mania is ultimately consigned. Depression is the offspring, the result, flowing from the recognition of shattered designs and ideals.

In the depressed phase of the manic-depressive psychoses, traits opposite to those of the manic symptoms are prevalent. Depression is mania in reverse. In depression everything is slowed up. The patient looks old, haggard, tired, and disinterested, though not as apathetic as in schizophrenia. He speaks as though he were dejected. There is harmony between his emotions, ideas, and actions. He says he is depressed; he seems depressed; and he acts depressed.

The depressive type of the manic-depressive psychoses is classified by the *Statistical Guide* under 001-x12 and is described: "Depressive type, with outstanding depression of spirits and mental and motor retardation and inhibition; in some cases, the mood is one of uneasiness and anxiety."¹⁸

Symptoms of Depression in General

1. There is intellectual, emotional, and physical retardation.
2. Psychic depression increases in malignancy in proportion to the type.
3. There is slowness or absence of speech.
4. There is inactivity, often amounting to stupor. There is sadness, not mere apathy or lethargy.
5. There is harmony of thought, word, and action.
6. There is a tendency to suicide.

Types of Depression

There are three subdivisions of depression: (a) simple retardation, (b) acute depression, (c) stuporous depression.

DEPRESSED TYPE, SIMPLE RETARDATION

1. There is harmony between thought, emotion, action, and speech.
2. Physical and psychic activities become retarded and sluggish.
3. There is difficulty in producing ideas, thinking, and reasoning.
4. Voluntary activity is abandoned and active choice has become very difficult.
5. Physical appearance of patient is depressed and lethargic; for the most part, he sits and does nothing.
6. Speech is slow though usually coherent.
7. The patient is harassed by fear, inferiority feelings, and the haunting realization that he has not made good but that his life has been a dismal failure.
8. There is no clouding of consciousness, though there may be some delusions and hallucinations. The delusions at this juncture are not systematized and are of a very depressing nature.
9. There is no marked disorientation.
10. There is no deterioration in mind, will, or memory. These powers are, however, inhibited.
11. Insight and judgment are impaired.

CASE 36: Manic-Depressive Psychoses, Simple Retardation

A female, aged 58, was admitted for a voluntary observation. Some three years ago the patient had become extremely "nervous," irritable, afraid of everything, and obsessed by the fear she would never become well. She cried a great deal, walked the floor, wrung her hands, was anxious, unable to sleep or eat well. She sought relief in a rest home and by taking a trip to California. These left her unimproved

and she was persuaded to enter the hospital for observation. On the ward she was very quiet, appeared dejected, did not mingle with other patients, complained of always feeling tired, spoke in a very slow, hesitating voice. She was unhappy and depressed, saying that she had nothing to be happy about. She exhibited no paranoid nor grandiose ideas and never heard voices. She was completely oriented and had a good grasp of present and remote events. She felt silly for being in her present condition. Physical examination revealed the presence of mild arthritis, hypertension, and arteriosclerosis.

The patient improved rapidly and was released to her husband within three months. Two months later she was back in the hospital. She was released again after six months of treatment, this time for two years. Then she was again returned for a period of twenty months to the hospital and finally released again.

DEPRESSED TYPE, ACUTE DEPRESSION

This is the second and more advanced phase of depression. It manifests all the traits of simple retardation but in a more intense degree. Acute depression is characterized by the following symptoms:

1. Marked gloom, sadness, and despondency.
2. Speech is low, inaudible, and frequently absent.
3. There is grave retardation in the realms of thought, will, and emotions.
4. There may be distressing somatic and hypochondriacal delusions.
5. Hallucinations, mainly auditory and visual, may be present.
6. Orientation is fairly well preserved.
7. The mind is basically preserved, but there is poor insight.
8. There is harmony between the thought, emotion, and action.
9. The combined picture presents a unit of depression.

CASE 37: Manic-Depressive Psychoses, Acute Depression

A married woman, aged 48, was admitted to the hospital, suffering from acute depression. She had led a happy marital life and had three normal children. There was no history of mental or nervous disorders within the family. She was in good physical health. All laboratory tests were negative. Previous to admission, she had suffered two attacks of depression, one fifteen years before and the other four years ago, at which time she attempted suicide. She was institutionalized after each experience for less than a year.

Within the two months prior to her present depression, two of her sons left home, one to be married and the other to join the Coast Guard. This upset her a great deal. She became very depressed

following this, cried excessively, worried over trifles, was unable to work, became irritable, and was not able to eat or sleep.

After admission to the hospital, the patient became very seclusive, uninterested in her surroundings, and dejected. Her actions were retarded. She responded in a slow, hesitant manner. She exhibited confusion and difficulty in thinking. She had entertained thoughts of suicide, but made no attempts. She was well oriented in all spheres. Her memory for events leading up to her admission was poor, and she possessed a good grasp of present information and fairly good insight. Under treatment, she improved rapidly and was discharged in a few months' time. One year later she was returned with the same complaint, but in eight months was again returned home.

DEPRESSED TYPE, STUPOROUS DEPRESSION

Clinically, this is the opposite of the hyperacute mania. Stuporous depression accentuates the symptoms of simple retardation and acute depression. Proper to itself, however, stuporous depression displays the following traits:

1. Extreme psychomotor retardation.
2. All the other symptoms of depression are accentuated.
3. There is extreme slowness in thinking, judging, and willing.
4. There is profound clouding of consciousness.
5. Orientation is gravely disturbed.
6. Delusions of a very perturbing nature occur, e.g., of persecution and guilt.
7. Suicidal tendencies are present during the period of lightening of the depression.
8. Extreme anorexia and insomnia are found.

CASE 38: *Manic-Depressive Psychosis, Stuporous Depression*

A married woman, aged 51, was admitted to the hospital because of a severe spell of depression. The patient had lived for many years on a farm and was happily married at the age of 20, and gave birth to eight normal children. She was hospitalized for depression for six months at the age of 23 and once again at the age of 28. About eight months previous to her last admission, her husband noted that she was unable to sleep and was becoming very "nervous" and irritable. She was taken to a hospital for a physical examination which proved to be negative. Upon her return home she became more depressed, complained of abdominal pain, became unable to work, and paced the floor and wrung her hands. It was then determined to have her institutionalized.

In the hospital she spent entire days lying quietly in bed, mute and without movement, or sitting quietly in a chair, slumped down as far as possible.

She did no work, was hand-fed, took no personal care of herself, soiled her clothing. Her facial expression was one of extreme dejection. Occasionally she responded to questions, but most of the time she continued mute. There were no evidences of hallucinations or delusions. She had ideas of sinfulness and unworthiness and thought she was a prostitute because she kissed her son. She wanted her husband to throw her out of the house because she was unworthy. She had ideas of suicide. She was almost completely disoriented and suffered from defective memory and impaired judgment. Her physical health was good.

CIRCULAR TYPE

In the circular type of manic-depressive psychosis the manic and depressed phases appear alternately. For the most part, there is no period of intervening lucidity. In general, the circular type of manic-depressive psychosis is considered malignant, and although prognosis for recovery from individual attacks may be good, it is generally unfavorable for complete recuperation. The alternate recurrences of mania and depression may exhibit any degree of intensity. The *Statistical Guide* has classified this phase of the manic-depressive psychosis as 001-X13 and has described it thus: "Here should be classified cases which show a change without a free or recovered interval of one phase to the opposite, i.e., when a manic reaction passes over into depressive reaction or vice versa."¹⁶

CASE 39: Manic-Depressive Psychosis, Circular Type

A fairly typical case of manic-depressive psychosis, circular type, is exhibited by the case of a young female, aged 17, who, in the course of eleven years, went to an institution eight times. On the first admission at 17 years, she was diagnosed as manic-depressive psychosis, manic phase. Three years previous to this commitment, at the age of 14, she had experienced a "nervous breakdown," during which she was severely depressed and stated that "her brain was all tired out."

After three and a half months, she was paroled to her mother. For seven months she got along nicely, worked part time, was in good health, and the family had no trouble with her. Seven months later, she returned from parole and manifested the symptoms of mania, for which she had first been committed. For six and one-half months she was treated, recovered, and was paroled again.

Within four months she was back in the institution, suffering from a severe case of depression. Within seven and one-half months she had sufficiently improved to be paroled. Five and a half months later, she attempted suicide and was brought back to the hospital, suffering from deep depression. Four months of treatment sufficiently cleared up the condition to warrant parole.

Within seven months she was again brought back, again suffering from depression precipitated by an auto accident in which her nose was broken. In about four months she was returned to her mother on parole. After a little less than a year she was brought back to the institution in a manic condition. It required eight months of treatment to return her to normalcy. At the end of that time she was again taken home.

Within slightly more than a half year's time she was again returned to the hospital. After four months of treatment she was returned home.

In six months she was returned, suffering from depression. At the end of six months she recovered and was returned home.

The case has not yet been closed and there may yet be further recurrences. All physical examinations revealed a normal female with pathology in none of the systems. The family history contained no history of mental disorders.

MIXED TYPE

The *Statistical Guide* has classified this phase of the manic-depressive psychoses under 001-X14 and has described it thus:

This term is not meant to apply to those cases that show transitory changes from depressive to elated moods or the reverse, but is for those cases that show a combination of the cardinal symptoms of manic and depressive states. Perhaps the most frequent of these is the *agitated depression*, i.e., a depression of mood but with increased motor activity and at times pressure of thought. Occasionally cases are seen of a so-called manic stupor in which there is elation and flight of ideas but with retarded motor activity amounting at times to complete immobility. Still other cases show elation of mood and increased motor activity, but without evident pressure of thought or flight of ideas, a so-called "un-productive mania."¹⁷

In the mixed types, the following types are recognized:

1. Manic stupor — emotional exaltation, decreased psychomotor activity, difficulty in thinking.
2. Agitated depression — emotional depression, increased psychomotor activity, flight of ideas.

3. Unproductive mania — emotional exaltation, increased psychomotor activity, difficulty in thinking.
4. Depressed mania — emotional depression, difficulty in thinking, increased psychomotor activity.
5. Depression with flight of ideas — emotional depression, flight of ideas, decreased psychomotor activity.
6. Akinetic mania — emotional exaltation, flight of ideas, decreased psychomotor activity ["Outline of Neuropsychiatry in Aviation Medicine"].

PERPLEXED TYPE

The *Statistical Guide* has classified this phase of the manic-depressive psychoses under 001-X15 and has described it thus:

In this type of reaction perplexity is an outstanding symptom in a depressive setting. Patients are apparently unable to understand their surroundings or they misinterpret them. Apparently, as a result of this, they may show strange symptoms and bizarre behavior. The prognosis in general is good, but the attacks may run a long course. Such patients are sometimes mistaken for cases of dementia praecox. The perplexity and general depressive reaction are differentiating features.¹⁸

PROGNOSIS FOR MANIC-DEPRESSIVE PSYCHOSES IN GENERAL

Much depends upon the prepsychotic personality of the patient. If he was bright, happy, and cheerful and made a fairly good adjustment, the danger of recurrence is relatively small. There seems to be a tendency for the hallucinatory rather than for the nonhallucinatory cases to recur.

Recovery from the single attacks is the rule. Recovery from manic-depressive psychoses is automatic, the disorder is self-limited and ultimate recovery frequent. There is, of course, a marked tendency to recurrence.

Of these patients, 55 per cent have one attack; 20 per cent have two attacks; 10 per cent have three attacks; and 5 per cent have four attacks. The remainder, a negligible percentage, have more than four attacks.

One attack, if untreated, may take eighteen months, or at least from fifteen to eighteen months for recovery. The manic phase, untreated, usually lasts six months and the depressed phase about nine months. This may be shortened very considerably, often to three months or less, through the use of modern therapies. Much better

results are obtained if the disorder begins abruptly. It is found that the patients who began with hallucinations recovered earlier than those who had no hallucinations. According to Rosanoff,¹⁹ there should be no lowering of mental powers on the recovery of the patient.

TREATMENT

The treatment of the manic-depressive psychoses falls naturally into two groups: (1) the excited patient, (2) the depressed patient.

The Excited Patient

An excited condition is one in which the patient is overactive. It may vary from an irritated mood to the boisterous excitement of the hypermanic patient. The milder degrees of excitement such as occur in the hypomanic patient are difficult to treat and in many instances even difficult to recognize. The patient, himself, usually feels no need for treatment, lacking as he does insight into his condition. The particular danger in this state is due to the fact that the patient, although he has an increased self-assurance, usually has defective judgment. He is inclined to take unnecessary risks which may not only endanger himself but others. Boisterousness and poor judgment frequently lead him into conduct which is unacceptable and he is particularly inclined toward promiscuous sexual behavior.

If home conditions are satisfactory, and the co-operation of the family and the patient can be obtained, they may be handled efficiently there. It should be borne in mind, however, that the patient is unreliable and is likely to change his mind frequently.

Most excited patients should be treated in hospitals equipped for their care. As the excitement increases the patient should be so placed that his poorly directed activities cannot cause damage to himself, the personnel, or the environment. Restraint should be avoided. If a patient has to be transported or is wearing himself out as a result of his overactivity, some type of restraint may be necessary.

Space does not permit a complete description of *methods of physical restraint*. There are, however, certain general principles which should be borne in mind. The first of these is the fact that where a nurse or attendant is injured, it is usually the fault of the individual concerned rather than the patient. Accidents may occur, but these should be rare. In handling disturbed patients, adequate help is necessary to avoid injury. It is not safe for one person alone to handle an excited patient. Much need for restraint can be avoided if the patient is observed

closely enough so that early in this period of excitement he can be removed to a quiet place where irritating stimuli will be absent.

Chemical restraint. Chemical restraint is of value particularly in handling acute situations and providing rest for the excited patient. When drugs are to be used, they should be given in adequate dosage because small dosage may serve only to excite the patient more. Effective drugs for this purpose are paraldehyde, nembutal, sodium amytal, and chloral hydrate. (See *Drug Therapy*, page 295.)

Mechanical restraint. Restraint of the patient by means of strait jackets, handcuffs, and similar means should seldom be necessary except during transportation or where inadequate psychiatric facilities are available. The most effective mechanical restraint is provided by the use of cold wet packs.

Hydrotherapy. Hydrotherapy is one of the oldest forms of psychiatric treatment. Its principal use is in securing sedation and for this reason it is of particular value in the handling of excited patients. A very satisfactory method of providing sedation is the *continuous tub bath*. The patient lies on a canvas hammock suspended in the tub. The water is allowed to run continuously and is maintained at a temperature of 98-99 degrees. For ordinary sedation the patient may be left in the tub for one or two hours. For more disturbed patients longer treatment may be given and, if proper attention to the skin is given, they may be left in the tub for days at a time. For such prolonged immersion the skin must be protected with grease and prompt attention must be paid to cutaneous infections which may develop.

A more potent sedative agent is the *cold wet pack*. The patient is securely wrapped in wet sheets and then wrapped securely in blankets. The first reaction is one of chilling, but the irradiation of body heat causes the temperature within the pack to rise and there is a secondary reaction of vasodilation which has a powerful sedative effect. It is especially useful in acutely disturbed patients, inasmuch as it provides a means of restraint as well as sedation. The duration of the pack depends on the reason for its administration and the physical condition and reaction of the patient. It is usually removed in from one to two hours, but in healthy patients it may be applied for longer periods.

The Depressed Patient

Every depressed patient is potentially suicidal. Many are driven to this extreme by the constant remonstrances of friends and family who admonish them to "snap out of it." It has frequently been said

that the person who talks about committing suicide never does so. This is not true. Constant vigilance on the part of those in attendance is necessary to keep the number of suicides at a minimum. There is no particular type of depression in which suicide is unlikely to occur. It should be remembered that these patients are not responsible for their actions and that previous training and religious beliefs will not deter them.

For this reason, depressed patients are better cared for in institutions. An occasional suicide will occur in even the best managed psychiatric institutions. Most commonly those who commit suicide do so by taking an overdose of a sedative, hanging, or cutting an artery, usually at the wrist. By patients outside of an institution, an infinite variety of methods have been used. The fact that a patient attempts suicide by taking a large dose of aspirin or some other means, not usually regarded as fatal, should not be considered too lightly under the impression that he is merely seeking attention. The patient had no knowledge of pharmacology and he may have thought that it would cause death. The only adequate precaution against suicide is to have the patient under observation constantly. A relaxation of vigilance for even a few minutes may give him the opportunity for which he has been seeking.

The *treatment of depression* is divided into five parts: (1) shock therapy, (2) psychotherapy, (3) manipulation of the environment, (4) drug therapy, (5) prefrontal leucotomy.

Shock Therapy

1. *Metrazol shock*. In 1934, Dr. L. von Meduna of Budapest introduced metrazol shock therapy. He had observed that epilepsy and schizophrenia very rarely occur in the same individual. He theorized that since the conditions did not occur together, there may be some antagonism between them. With this in mind he experimented with a variety of drugs seeking one that would cause a convulsion. He discovered that metrazol, which was used as a circulatory stimulant in small doses, would quite regularly cause a convulsion if given in larger doses. The dosage which he arrived at was 4 cc. of a 10 per cent solution for women and 5 cc. of a 10 per cent solution for men. This was given intravenously and would almost immediately produce a convulsion. The treatment would be given every other day until 25 shocks had been given. One great disadvantage of metrazol therapy was fear of the treatment, so that the individual approached each

treatment with severe apprehension. The greatest complications of this type of shock therapy were fracture and dislocations which resulted from the violent contraction of the muscles. These dangers could be minimized if the patient is properly restrained.

2. *Electroshock*. There are many disadvantages of metrazol shock therapy, among which as mentioned above are the extreme apprehension of the patient in regard to the treatment and the difficulty of determining the proper dosage and in controlling it once it has been administered. The induction of convulsions by the use of electrical current sent through the frontal lobes of the brain from electrodes placed over the temples has largely replaced metrazol shock therapy.²⁰ This method has the advantage of producing instantaneous unconsciousness and is more easily controlled. The period of amnesia after the convulsion obliterates the memory of the actual treatment. The number of treatments required by this method is variable and depends to a certain extent on the patient's response. The usual course of treatment consists of 6 to 8 grand mal seizures for depressions and about twice this number for schizophrenic patients.

Electrical convulsion therapy (E.C.T.) has its greatest value in depressions. It is most effective in agitated depressions (involuntional melancholia) and in reactive depressions. In cases properly diagnosed as such, about 85 per cent of the patients will be markedly improved or recovered after six to eight treatments. Of these, about 15 per cent will relapse usually within a month. Of those who relapse, about 85 per cent will recover with a second course of treatment. In the depressed phase of the manic-depressive reaction, 60 per cent complete remission and 20 per cent marked improvement may be expected. In the excited phase of the manic-depressive reaction, 50 per cent remissions may be expected and 20 per cent marked improvement. In schizophrenia the results with E.C.T. are less dependable. However, in catatonic patients about 60 per cent remissions may be expected on the first admission. In other types of schizophrenia the results are less predictable. The results here depend not only on the type of the disease but upon its duration and severity. If the patient has been sick less than six months, the prognosis in all types is improved. Lovinger and Huddleson reported a somewhat lower remission rate in a series of 125 schizophrenics who were given a course of 20 grand mal seizures. They reported a 45 per cent remission in this series. No remissions occurred when the duration of the disease had been

two years or more. Regardless of duration their remission rate for cases with an acute onset was 34 per cent, and for cases with an insidious onset was 15 per cent.

The incidence of fractures has always been disturbing with all types of convulsive therapy. Although the incidence of fractures was less with electric shock than with metrazol, it still occurred in a significant number of cases. Although fractures of the leg bones occurred occasionally, the most frequent injuries were compression fractures of the vertebrae. This is understandable if the nature of the treatment is understood. When the current is applied, there is a sudden strong contraction of the muscles of the trunk. This is the tonic phase of the convulsion. This phase is quickly followed by generalized jerking movements of the muscles. This is the clonic phase. It is during the sudden violent muscular contraction that the fractures occur. The seizure resembles an epileptic attack in all respects except that in epilepsy the tonic phase develops more slowly and with less suddenness and violence (see p. 502).

It is interesting to note that these compression fractures very seldom produce any marked symptoms or require any special treatment. This was especially true when the individual was unaware of the fact that such an injury had occurred. In a small percentage of those who knew of this injury, the idea that they had a "broken back" produced marked psychological reactions.

In an effort to avoid these fractures, many techniques have been devised including the administration of anesthetics, methods of applying the current which cause it to reach its peak slowly (glissando), methods of holding the patient, and the use of muscular relaxants. For a while curare was considered to be the solution of this problem, but its effect is prolonged and as a consequence prolonged apnea occurred and occasional deaths followed. A newly used drug, Succinylcholine, avoids these difficulties, and during the two years of its use has reduced the number of fractures of all types to an insignificant figure. The dosage of this drug depends on body weight and the result which one expects to achieve. If the desired result is merely to "soften" the seizure, a small dose is given. In order to eliminate the seizure entirely, a much larger dose is given but artificial control of respiration is needed until natural breathing is resumed.

Since some patients are very apprehensive either because of their illness or through fear of the treatment, some physicians will give

an intravenous sedative so that the patients will be asleep when they are treated. This adds somewhat to the risk of the treatment and we have seldom found it necessary or desirable.

No one knows exactly how electroshock produces its results. It is our impression that although the procedure is physical in its technic, its results are psychological. In our culture, death is the supreme penalty. The depressed patient always has strong feelings of guilt which, though irrational, are nevertheless painful to the individual. As a result he feels a need for punishment. The unconsciousness accompanying the treatment he accepts as symbolic of death. This satisfies his need for punishment and he can then allow himself to get better. It has been said that electroshock "spanks the unconscious."

Electroshock is seldom a cause of death. About one death in 100,000 treatments may be expected.

Contraindications to electroshock therapy:

1. Certain bone and joint conditions such as recent fractures and osteoporosis.
2. Intracranial lesions such as brain tumors, recent cerebral hemorrhages, increased intracranial pressure from any cause.
3. Pulmonary lesions especially active pulmonary tuberculosis.
4. Severe systemic diseases such as diabetes, hyperthyroidism, blood dyscrasias.
5. Cardiovascular lesions such as congestive heart failure and recent coronary infarction.²¹

Psychotherapy

There is a very prevalent opinion that shock therapy is the whole answer to the treatment of depressions. Many well-qualified psychiatrists speak of curing depressed patients. This is far from the truth. The depressed patient is very similar to the patient in a diabetic coma. The physician who would treat a patient in a diabetic coma and then send him on his way as cured would be obviously in error, since the patient still has the diabetes which produced the coma. This same thing is true in depression. The patient who is given electroshock for his depression is not cured, but merely relieved of a severe exacerbation of his underlying psychopathology. The elements which produced his depression are still present and an effort should be made to resolve these conflicts during his more lucid intervals.

Manipulation of the Environment

Since environmental influences play a large part in all personality development, this factor is important in the case of depression. In the case of reactive depression, environmental factors are of paramount importance and should never be ignored. Very few suggestions can be offered beyond this, however, as each case must be decided on its own merits. Care must be exercised not indiscriminately to advise trips away from home, ocean voyages, and the like. Such advice should be offered only after very careful study and when one is assured that there is something to be gained. In most cases, all things being equal, the mentally ill patient is best treated in a familiar environment.

Drug Therapy

No drug of real value in the treatment of depressions has yet been discovered. The drugs most commonly used are benzedrine sulfate, dexedrine sulfate, and meratran. In mild states of depressions or of chronic fatigue, any of these drugs is likely to be effective. Dexedrine is the most constantly helpful. In cases of depression with agitation, some sedative may be required in addition to the stimulant. Although it may seem inconsistent to combine a sedative and a stimulant into one dose, it has great value in such cases.

In severe depressions these drugs have practically no value, even for the relief of symptoms. They have no curative value in any case.

The administration of estrogenic hormones has been regarded by many physicians as beneficial in involutional melancholia. This is based on the concept that this psychosis is a phase of menopausal syndrome. There is little to support this view and the use of hormonal therapy has been largely discontinued.

Prefrontal Leucotomy

Prefrontal leucotomy was first suggested in 1936 by Moniz, a Portuguese surgeon. It was introduced into this country by Freeman and Watts in 1942. At an international convention of "Psychosurgeons" held in Lisbon in 1948 approximately 8000 cases of prefrontal leucotomy were reported. The operation usually performed is the severance of the association tracts in the frontal lobes, bilaterally in the plane of the sphenoidal ridge. No tissue is usually removed. Several variations of this procedure have more recently come into use. Topectomy introduced by the Columbia-Greystone Associates and

transorbital lobotomy are the best known of these procedures. The operation is most commonly recommended in four types of cases, (1) schizophrenia, (2) agitated depressions, (3) obsessive tension states, (4) intractable pain.

Freeman and Watts²² claim satisfactory results in 80 per cent of their cases of agitated depression but advise a trial of E.C.T. first. In obsessive tension cases they state that they have returned 75 to 90 per cent to a useful existence. Other authors are almost equally enthusiastic. All recommend that the operation should be performed only on those cases who are incapacitated and unable to work. Many unsuccessful operations are blamed on erratic behavior which they believe was part of the prepsychotic personality of the patient.

As lobotomy is supposed to relieve certain symptoms, patients are chosen for this operation not primarily by diagnostic classification but rather by the presence of a group of symptoms. These symptoms in the order of their importance are (1) introversion, (2) pre-occupation, (3) nervous tension, (4) obsessive thinking, (5) worry, (6) anxiety, (7) depression, (8) indecisiveness, (9) exhaustion, (10) insomnia, (11) crying spells, (12) suicidal ideas.

The results of the operation from the standpoint of curing the patient are still under study. There seems little doubt that it relieves nervous tension and makes the patient more tractable. It has, however, certain side effects which may be less desirable than the original symptoms. Comments such as the following are frequently seen in postoperative reports:²³ "Since the operation the patient has been tactless, rude, and lazy." "Has lost his sense of time [according to Freeman 'time orientation' is represented in the frontal lobes]." "She talks too much . . . nothing embarrasses her . . . she talks about everybody to anybody." "He stood in front of the mirror and shaved all night." "He acts like an observer; he never seems like one of the crowd anymore." An interesting sequel to a leucotomy is that successful cases no longer dream; whereas, dreams persist in unsuccessful cases.

MORALITY OF LOBOTOMY

As in all cases involving mutilation of the body the question of the morality of the procedure has been widely discussed. The principle to be applied in answering this question is this:

Any procedure harmful to the patient is morally justifiable only in so far as it is designed to produce a proportionate good.

For a discussion of the principle as it applies to lobotomy, reference should be made to articles by Kelly,²⁴ O'Rahilly,²⁵ McCarthy,²⁶ and O'Brien.²⁷ In general the conclusion has been that in capable hands and for the treatment of conditions which have not responded to other means of therapy the operation is permissible. For example Kelly²⁸ concludes:

Lobotomy is morally justifiable as a last resort in attempting to cure those who suffer from serious mental illness. It is not allowed when less extreme measures are reasonably available or in cases in which the probability of harm outweighs the probability of benefit.

McCarthy²⁹ somewhat amplifies this opinion but is substantially in agreement with Kelly:

It seems to us that the operation of prefrontal leucotomy is lawful provided it be performed, with due permission, by an expert brain surgeon, as a last resort, for the relief of serious mental disorders of a type which seems likely to benefit therefrom and provided post-operative guidance and treatment are available.

We are thoroughly in accord with these opinions.

SUMMARY

The manic-depressive psychoses are psychogenic disorders which are the second most frequent of the psychoses. About 15 per cent of those admitted to mental institutions have this classification. A physical origin for this disorder has frequently been postulated but there is very little evidence that this is true. There are many varieties of this disorder. The classical cyclic type is not very common. More frequent are those patients who have two or more attacks of either mania or depression without an intervening attack of the other type. The treatment of these disorders is unsatisfactory and the most which can be looked for at the present time is some shortening of the attack. The most effective measures to accomplish this are hospitalization and electroshock.

FOOTNOTES

1. Emil Kraepelin, *Lectures on Clinical Psychiatry* (New York: William Wood and Co., 1914), pp. 61-78.
2. Samuel H. Kraines, *The Therapy of the Neuroses and the Psychoses* (Philadelphia: Lea and Febiger, 1941), p. 355.
3. Edward A. Strecker, *Fundamentals of Psychiatry* (Philadelphia, London, and Montreal: J. P. Lippincott Co., 1943), p. 100.
4. Kraepelin, *op. cit.*, pp. 61-78.

5. Horatio M. Pollock, Benjamin Malzberg, and Raymond G. Fuller, *Hereditary and Environmental Factors in the Causation of Manic-Depressive Psychoses and Dementia Praecox* (Utica, N. Y.: State Hospital Press, 1939), p. 43.
6. U. S. Army, "Outline of Neuropsychiatry in Aviation Medicine," *Technical Manual 8-325* (Washington, D. C., December 12, 1940), p. 30, par. 17 (q).
7. Pollock, Malzberg, and Fuller, *op. cit.*, p. 43.
8. Roy M. Dorcus and G. Wilson Shaffer, *Textbook of Abnormal Psychology*, 2 ed. (Baltimore: The Williams & Wilkins Co., 1942), p. 366.
9. P. M. Lichtenstein and S. M. Small, *A Handbook of Psychiatry* (New York: W. W. Norton and Co., Inc., 1943), p. 167.
10. *Technical Manual 8-325*, p. 19, par. 10 (a).
11. *Ibid.*, p. 100, par. 67.
12. Edward A. Strecker, *Fundamentals of Psychiatry* (Philadelphia: J. B. Lippincott Co., 1943), p. 100.
13. *Statistical Guide* (001-x11) (State of New York, Dept. of Mental Hygiene), compiled by H. M. Pollock, 12 ed. (Utica, N. Y.: State Hospital Press, 1943), p. 32.
14. *Technical Manual, 8-325*, p. 45.
15. *Statistical Guide* (001-x12), p. 32.
16. *Ibid.* (001-x13), p. 32.
17. *Ibid.* (001-x14), p. 32.
18. *Ibid.* (001-x15), p. 32.
19. Aaron J. Rosanoff, *Manual of Psychiatry*, 7 ed. (New York: John Wiley and Sons, 1938), p. 592.
20. There is a great difference in the amnesia in metrazol and electroshock treatment. When metrazol was used the patient convulsed first, then became unconscious. It was the memory of the convulsion that made patients fear metrazol and beg not to have to take it. In electroshock treatment the patient becomes unconscious first and then convulses. For this reason the patient does not usually object to repetition of this form of treatment.
21. *Progress in Neurology and Psychiatry*, Vol. III, ed. by E. A. Spiegel (New York: Grune & Stratton, 1948), p. 576; R. Kaldeck, *et al.*, *New England J. Medicine*, 239:773-779, November 18, 1948.
22. Personal communication with W. Freeman and J. Watts.
23. *Ibid.*
24. Gerald Kelly, S.J., *Medico-Moral Problems* (St. Louis: Catholic Hospital Association, 1950), Part I, p. 43.
25. Ronan O'Rahilly, "Prefrontal Leucotomy," *The Catholic Nurse*, XVI (December, 1948), 7-9.
26. Father J. McCarthy, "The Morality of Prefrontal Leucotomy," *The Irish Ecclesiastical Record*, LXXI (May, 1949), 433-438.
27. Father Patrick O'Brien, C.M., "Prefrontal Lobotomy: Its Present Moral Aspect," *The American Ecclesiastical Review*, CXIX (September, 1948).
28. Kelly, *op. cit.*, p. 43.
29. McCarthy, quoted by Gerald Kelly, S.J., *Medico-Moral Problems* (St. Louis: Catholic Hospital Association, 1950), Part II, p. 44.

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INVOLUTIONAL MELANCHOLIA: AGITATED DEPRESSION

DEFINITION

Involutional melancholia may be defined as a grave mental disorder of psychogenic origin occurring usually during the involutional period and characterized by anxious depression and delusions usually of a melancholic nature.

Psychogenic origin. The etiology of this disorder is obviously not to be sought for exclusively or principally in the physiological changes occurring at this period. It is considered by almost all authorities to be a psychogenic disorder. Although agitated depressions *occur usually during the involutional period*, they may occur before it, even at a very early age. For this reason, many prefer the term "agitated depression" to "involutional melancholia."

Anxious depression and delusions, usually of a melancholic nature, are found in syndromes other than involutional melancholia. When *these symptoms occur simultaneously during the involutional period*, they constitute a sufficiently distinctive syndrome to warrant separate consideration.

Before proceeding to a further discussion of this subject, it should be made clear just what symptoms are to be expected as a result of the endocrine changes occurring during the involutional period.

THE CLIMACTERIC

Although the terms "climacteric" and "menopause" are often used as synonyms, they do not refer to the same thing. The term "*menopause*" means merely cessation of the menses, whereas the term "*climacteric*" refers to the whole series of changes which accompany or follow this event. The cessation of the menses usually occurs around the age of fifty years. In most cases, the regularity of the flow is disturbed and the periods occur at gradually increasing intervals until they finally cease.

In a relatively large number of women, no unusual symptoms accompany the menopause. In a much smaller number, however, there are moderately severe symptoms.

In the average individual, the symptoms occurring during the climacteric which are due to decreasing ovarian function consist of:

1. *Hot flushes*, which may vary from a few a day to several an hour. During the attack, the patient usually appears flushed and experiences a sensation of warmth. This may be followed by a profuse sweat.

2. *Hot flushes*, which may occur only occasionally or many times a day. They are less frequent than hot flushes but more disturbing because of their greater intensity. These are usually described as a sensation such as might be produced by a hot knife passing through the body. They are of short duration.

3. *Obesity*. The increased fat is most frequently deposited on the hips and abdomen.

4. *Headaches*.

5. *Increased irritability*. This is chiefly characterized by emotional instability.

A similar period of change is frequently noted in the male. The male menopausal changes resemble in a general way, although to a lesser degree, those occurring in the female.

Since the cause of the climacteric symptoms is the failure of the body to adjust to the gradual decrease in the gonadal secretion, their treatment is obvious. We need only to replace artificially the deficient hormone and the symptoms will be relieved. The vast majority of patients will recover from their symptoms by such therapy. Many of these patients are greatly disturbed mentally not because of deficient hormones but because they feel that the menopause is evidence of advancing years. They have noted other evidences of this in graying hair, increased weight, and decreased physical attractiveness. They fear that they will lose their sexual desire and appeal. Much relief may be afforded these patients by explaining to them that sexual feeling is not dependent on the presence of the menses and that the changes accompanying age are not necessarily unattractive. The unpleasant vasomotor phenomena, however, can, in practically all instances, be relieved by the administration of adequate dosage of the estrogenic hormones in the female and testicular hormones in the male.

An important point of distinction between symptoms which result from the endocrine changes and those merely concomitant with them is the fact that the first group will be relieved by replacement therapy, whereas the concomitant group is unaffected.

HISTORY OF INVOLUTIONAL MELANCHOLIA

Prior to Kraepelin's studies, all types of mania and melancholia were treated separately and each was considered to have its own etiology, syndrome, course, prognosis, and therapy. For several years after the recognition of the manic-depressive syndrome, Kraepelin continued to regard involutional melancholia as a specific type of mental disorder which first appeared in connection with the presenile period. He was, however, compelled to separate manic-depressive psychoses from the involutional psychoses for many reasons, particularly the following:

1. There was the *absence of previous attack*.
2. The *depression* attached to involutional melancholia was usually very *severe* and was associated with *anxiety* and *agitation*.
3. The *content of the delusions* differed from that of the manic-depressive psychoses.
4. The *prognosis was relatively unfavorable*.

It was obvious that this group of symptoms was not to be found in this co-ordinated and combined form in the manic-depressive patients. For this reason, Kraepelin, while combining mania and melancholia, in the manic-depressive psychoses, kept this syndrome of involutional melancholia separate and treated it as an entity in itself.

Many psychiatrists with good reason agreed to this separation of involutional melancholia from manic-depressive psychoses. Dreyfuss, an assistant of Kraepelin, was a strong proponent of the opposing view. Although he apparently convinced Kraepelin at a later period of the soundness of his views, his work has not been convincing to later students of the subject. Jelliffe and White are not impressed by the findings of Dreyfuss. They observe:

Even admitting that this group of involutional melancholias really belong to the manic-depressive psychoses, still the problem is not wholly solved, and it must be admitted that in all probability the involutional period has certain modifying effects on the psychosis. . . . In the first place the depressions as noted, heretofore, are very much more frequent than the excitements and they are very much longer in duration than during earlier life. This, of course, can be easily understood by the failing resistance of the involutional period.¹

It would seem to us that the majority of patients reported by Dreyfuss should never have been classified as involutional psychotics. Practically all of them display the symptoms of the manic-depressive

psychosis. This is the opinion of Kirby quoted by Henderson and Gillespie: "In a number of cases the manic-depressive symptoms were plainly in evidence, the cases having been improperly placed with the melancholias. In a considerable number of other cases, the author's conclusions that manic-depressive symptoms were present is based on extremely meager data."² Speaking for themselves, Henderson and Gillespie say:

We agree with this conclusion of Kirby's, and are not willing to accept the Dreyfuss-Kraepelin findings. We believe that there is a group of cases which we can term involuntional melancholia, distinct from manic-depressive states. We believe from a study of a group that we have sufficient evidence that involuntional melancholia is a relatively common type of mental disorder, and has certain features of its own. These features are depression without retardation, anxiety, a feeling of unreality, and hypochondriacal or nihilistic delusions, the last being in the allo-, somato-, and auto-psychoic fields.³

Tredgold holds involuntional melancholia as distinct from manic-depressive psychosis.

There has been much discussion as to whether this type of melancholia is not merely a phase, it may be the final one, of a manic-depressive psychosis. There are undoubtedly some cases arising at this period of life in which there have been previous attacks of depression or elation, and such may rightly be placed in this category. There are many others in which this is not so. In these, there is often a history of mental instability or of a proneness to worry over trivialities, but there has been no actual mental breakdown. In many cases, the present attack has followed some bereavement, business worry, financial loss or physical ill-health; but actually it is a pathological reaction, involving both thought and feeling, consequent on the mental and physical changes of the involuntional period of life. It is to these that I shall restrict the term involuntional melancholia. It is sometimes termed climacteric melancholia. On the whole, however, it presents sufficiently distinctive features to justify its description as a separate type.⁴

Other authors, however, follow the opinion of Dreyfuss, and they describe, inaccurately, we think, involuntional psychoses as the mixed form of manic-depressive psychoses. Representative of such authors is Rosanoff, who describes involuntional melancholia after the following fashion:

Perhaps the commonest type of mixed manic-depressive attacks is that generally known as agitated depression. This may occur in an adult

of any age, but is seen rather characteristically in late middle life or in early senility; hence it is often spoken of as involuntional melancholia. This type of manic-depressive psychosis is particularly likely to run a protracted course and by reason of the constant restlessness, sleeplessness, loss of appetite and extremely painful and anxious depression, often leads to progressive loss of flesh. Among cases of this condition there is a mortality of 20 or 25 per cent due not directly to the psychosis, but to suicide or to some intercurrent infection such as pneumonia, influenza, enteritis or tuberculosis, to which the patients are rendered liable by their run-down physical condition and to which they succumb on account of their lowered resistance. The surviving patients, however, eventually recover, as a rule, as they do from other types of manic-depressive attacks.⁵

Kraines,⁶ and a few other authors, as well as Kraepelin himself, call involuntional melancholia "agitated depression," a term which has much merit. We believe that the original scheme as worked out by Kraepelin is superior to that of Dreyfuss.

AGE OF ONSET

Owing to personal factors and individual differences, it is extremely difficult to say when the involuntional period begins. The involuntional decades are 35 to 55 years. Several authors give different dates for the approximate age of onset of involuntional melancholia, ranging from 40 to 65 years. It is interesting here to compare the age of onset of manic-depressive psychoses with the above age periods during which involuntional melancholia is likely to occur. In the manic-depressive psychoses, 60 per cent have the disorder before they reach the age of 25 years; 30 per cent between 25 and 40; and 10 per cent after the age of 40. Although involuntional melancholia usually occurs after the age of 40 years, it may, as indicated above, occur in the form of an agitated depression at a much earlier age.

INCIDENCE

Dr. James V. May,⁷ analyzing reports from 48 different state hospitals, shows that involuntional melancholia constituted 2.53 per cent of over 70,000 admissions. In 49,640 first admissions to the New York hospitals during a period of eight years, there were 1351 cases diagnosed as involuntional melancholia—2.72 per cent of the total. During 1918 and 1919 these hospitals showed 480 cases, or 3.45 per cent of 13,488 first admissions. The cases of involuntional melancholia

were 2.25 per cent of the admissions to the Massachusetts State Hospitals in 1919. Twenty-one public institutions in 14 other states reported 378 cases, or 2.06 per cent of 18,336 admissions. These reports show a remarkable unity of opinion in regard to this psychosis, its distinction and classification in the United States.

THE ROLE OF ENDOCRINE DYSFUNCTION IN INVOLUTIONAL MELANCHOLIA

The most diversified causes are credited with the production of involutional melancholia. Dorcus and Shaffer claim that involutional melancholia must be viewed as the result of physiological change. They say: "The period must be viewed as a physiological epoch associated with certain failures in the glands of internal secretion and resulting in a lowering in bodily health and disorganization of the mental faculties."⁸

These physiological changes to which various psychiatrists refer are common to all men and women between the ages of 40 and 60. And yet, despite the fact that all are subjected to this common biological change, comparatively few develop involutional psychoses—2 to 3 per cent at most. There are, as we have observed, physical changes. They are well described by Jelliffe and White.

With the recent work that has been done on the ductless glands and with the somewhat characteristic mental pictures that go along with disturbances of the internal secretions, one must bear in mind that perhaps many of the changes of the involutional period are, in part at least, determined by changes in these ductless glands. Particularly as the result of atrophy of the uterus, the ovaries, the prostate, the testicles and the adrenals, with the possible result of an imbalance being brought about in the relationship between them. This, of course, if it is so, would only be one of the modifying factors of the involution period which one might expect to see reflected in the diseases at this time of life.⁹

The appearance of involutional melancholia about the time of the menopause has often given the impression that involutional melancholia is caused by the glandular, vegetative, and nervous disturbances occurring at this time of life. This supposition is probably connected with the menopause. It is, of course, incorrect. For all women, if they live long enough, go through the menopause, while only a very few develop involutional melancholia. This physiological epoch is associated with a certain failure in the functional activity

of the endocrine and reproductive glands and results at times in a lowering in the physical condition. Many symptoms of the menopause, consisting of vasomotor disturbances, sweating, headache, irritability, and some degree of insomnia, are due largely to the sudden diminution of endocrine activity and can be aided by proper therapy. Many modern psychiatrists are of the opinion that the physical features have but little significance, etiologically, in this psychosis. At most, the physical failure in the functional activity of the endocrine and reproductive glands plays only a small or aggravating role. While it is true that the climacteric is characterized by certain physical manifestations, its so-called "dangers" have been grossly exaggerated by misinformed lay people, as well as by some in the medical profession. True involutional psychosis is based on deeper and more complicated factors and should not be confused with the menopause, which is as natural a process as adolescence.

HEREDITY

Sadler¹⁰ ventures the opinion that about 60 per cent of cases of involutional melancholia are due to heredity. If the biological changes of the involutional period or other organic factors were the main cause of the disorder, the assertion might be intrinsically possible. Since nonsomatic, psychological forces are probably more responsible, the possible influence of heredity, strictly understood, is considerably diminished. Few other authorities, if any, share this opinion. Sadler offers no substantiation.

PSYCHOGENIC ORIGIN

Since there is no very pronounced physiological change characteristic or productive of involutional melancholia, we must look elsewhere for its actual cause. Investigation reveals that etiologically the psychological factor is very prominent in involutional melancholia. An analytical review of the history of those patients reveals a similarity of *pre-psychotic personality* traits, so characteristic as to be frequently called a *rigid personality*. They are of the inhibited type, sensitive and meticulous, colorless and frugal, intolerant, humorless, prudish, pre-occupied with alimentary function, overconscientious, reticent, inclined to jealousy, suspicion, and excessive worry, and almost compulsive in following a routine. A chronic sense of ego insecurity, a narrow range of interests with difficulties of readjustment and inability to maintain friendships are also characteristic of this type. These traits, it will be

noted, have little or no similarity to the manic-depressive's history.

Involucional melancholia is not, therefore, causally due to hormonal alterations nor to physiological changes. Ninety-seven per cent of those who encounter such alterations do so gracefully and are able to meet the conflicts of advancing years. They are able to realize that their life henceforth will be continually slowing up, that their images will be fewer, and that memory will be defective, that they have traveled the road of life and are coming toward its end. For many, however, this idea is naturally depressing. This is especially so if such people have no adequate philosophy of life. It is so even for those with a sound philosophy of life, for even these need to meet daily problems adequately.

Henderson and Gillespie¹¹ found that in the Glasgow Royal Mental Hospital 57 per cent of the women and 70 per cent of the men broke down as a result of psychic factors, whereas physical factors were of importance in only 21 per cent of the women and 6 per cent of the men. These figures are in agreement with those of William Mabon, who found that in his involucional cases 47 per cent were of psychic origin, 34 per cent of physical origin, and 17 per cent were due to a combination of both of these factors.

Precipitating psychic factors include any form of mental strain or shock. Such factors may be the death of near relatives, breaking up of the home, unhappy home life, business failure, retirement from business or military service, financial distress, or inability to compete with others.

SYMPTOMS

1. The history reveals in these patients three facts which are of considerable diagnostic significance:

- a) There is *no history of a previous attack*.
- b) The patient is *usually over 40 years of age*.
- c) There is evidence of a *rigid prepsychotic personality*.

2. The *onset* of the condition is usually insidious and it may be difficult for the patient or his family to date its onset exactly.

3. *Depression is consistent*, profound, annoying, and irritating. This is mainly a psychological depression.

4. *Anxiety, apprehension, fear, worry*. There is restlessness to the extent of preventing sleep, loss of appetite, loss of weight, and uneasiness. The patient seems unable to be at ease, walks back and

forth, sighing and moaning, looks dejected, and frequently wrings his hands. Despite that, there is *no confusion*, there is *correct orientation*, and *psychic powers are alert*.

5. *Delusions of guilt or self-blame*, e.g., there may be delusions of poverty, of want, and of starvation. There may be self-accusatory delusions, the patient has committed an unpardonable sin, and is therefore unworthy of life or food or friendship. He claims that he deserves jail and death. He deserves hell for all eternity. He feels he is already suffering such pains.

6. *Delusions of hypochondriasis*. These delusions take all shapes and forms. The patient may feel that it is impossible to recover from his present disease, that he has a whole combination of incurable disorders, that his heart, lungs, kidneys, brain, and all his organs are diseased and irreparably so.

7. *Delusions of nihilism*. His organs have faded away; so also his brains; nothing remains.

8. *Delusions of unreality*. Everything seems different to the patient and not its exact self. According to Henderson and Gillespie, "the most characteristically involuntional qualities lie in the content of the psychosis, especially in the apprehension, hypochondriasis and nihilism, and these qualities are the result of the psychological changes associated with advancing years."¹²

9. *Hallucinations* of a terrifying nature are frequently present. These hallucinations are especially strong in the visual and auditory fields.

10. *A suicidal tendency* exists mainly because of the hallucinations and delusions.

The following case report shows many of the characteristics of the disease:

CASE 40: *Involuntional Melancholia*

A woman, aged 51, was brought for observation because of severe agitation. Her family history was negative. Birth and early development were normal. She had completed high school education, and a business course. She had been a telephone operator for twenty-two years. She was a good mixer, friendly, high strung, and "nervous." She married the first time at 18, but as her husband was unfaithful to her, she divorced him and married again. She had two children, one of whom was in a school for the blind, having become blind at two years of age.

Prior to admission the patient became unduly restless, agitated, worried, and began talking in a rambling, irrational, loud, and in-

coherent manner. She began worrying about her son in the school for the blind, worried for fear her husband and neighbors were not "going to be saved." She was depressed and wept a great deal. She repeated the name "the neighbors" over and over again in response to a voice within her. Following a meeting which she and her husband attended, she became hysterical, jumped out of bed, ran out of the house, and knocked her head against the door repeatedly. She finally collapsed and lay on the floor, resisting all aid. She finally sat up, of her own volition, stared about her, and began to scream.

At first the patient was very agitated, resistive, would not eat, took no part in ward activities. Following a course of electroshock therapy, this condition was improved. She told about her concern over her son and about some debt she owed. She denied being mentally ill. Physically, she showed a chronic asthma and had stopped menstruating about two months before. She had experienced "hot flashes" intermittently during the past five years. Six weeks after admission she had gained insight into her condition and realized she had been mentally ill. Her worries were entirely dispelled, she recognized that she had entertained auditory hallucinations for which there was no factual basis, and presented the picture of a normal individual.

DIFFERENTIAL DIAGNOSIS

A detailed comparison of their respective diagnoses will reveal the impressive difference existing between involutional melancholia and manic-depressive psychosis:

<i>Manic-depressive psychosis</i>	<i>Involutional psychosis</i>
1. History of previous attacks.	No previous attacks.
2. Age of onset: 60% before 25 years of age, 30% between 25 and 40, 10% after 40.	Age of onset: first appearance during the involutional decades, between 35 and 55. Ninety per cent or more occur after the age of 40.
3. There is a tendency to recur.	Less tendency toward recurrence.
4. Suicide is but rarely attempted, and then usually during recovery from deep depression.	There is permanent danger of suicide, particularly when the hallucinations (auditory) are vivid.
5. Hallucinations are unusual and occur mostly in acute or stuporous mania.	The hallucinations are frequent and are of a most depressing nature.
6. Apprehension and agitation are moderate, if present.	Apprehension and agitation are pronounced.
7. Depression retards all functions, psychic and physical.	Much less retardation.

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|---|---|
| 8. Delusions are rare in the manic condition and are not very intense in the depressed phase. | Delusions are very frequent in all spheres. |
| 9. The agitation of the manic-depressive is psychosomatic, e.g., it manifests itself in both thought and muscular activity. | The agitation of the involutional depressive is mainly psychic and is stimulated by apprehensions, delusions, and hallucinations. |

PROGNOSIS

The prognosis of this disorder is good since the advent of the shock therapies (cf. treatment). About 90 per cent of those affected recover. It may run from six months to three years if untreated. Twenty per cent of the patients formerly died from physical disease or by suicide. The prognosis for recovery depends greatly upon the extent and type of prepsychotic development.

In general, the outlook is more favorable when grave delusions of persecution, poverty, or death are absent, and when profound anxiety or restlessness are absent.

The outlook is unfavorable when the disorder lasts more than three years, when there are gross somatic and nihilistic delusions, and when there is serious arteriosclerotic or other pathological cerebral involvement.

TREATMENT

Since the institution of the various shock therapies, particularly electroshock therapy, the prognosis for this condition is greatly improved. This treatment has been previously described in the chapter on Manic-Depressive Psychoses and, as indicated there, involutional melancholia gives the best response to this type of treatment. Psychotherapy is frequently of value; however, it is most effective when administered following a course of electroshock therapy.

SUMMARY

This type of depression must be carefully differentiated from the depressions associated with the manic-depressive psychosis. An important point of distinction is that in the involutional depressions there is no history of a previous attack. The term "involutional melancholia" is misleading because although these depressions frequently occur at the involutional period they may occur at much younger ages. The term "*agitated depression*" is to be preferred.

The climacteric changes in the individual are not the cause of the involutional depressions. They are psychogenic in origin and related to a feeling of failure in the individual. Electroshock therapy is the most effective means of therapy but should be given in association with psychotherapy.

FOOTNOTES

1. S. E. Jelliffe and W. A. White, *Diseases of the Nervous System*, 6 ed. (Philadelphia: Lea and Febiger, 1936), p. 1093.
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6. Samuel H. Kraines, *The Therapy of the Neuroses and the Psychoses* (Philadelphia: Lea and Febiger, 1941), p. 21.
7. James V. May, *Mental Diseases* (Boston: Richard G. Badger, The Gorham Press, 1922), p. 439.
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9. S. E. Jelliffe and W. A. White, *Diseases of the Nervous System* (Philadelphia: Lea and Febiger, 1929), pp. 1093-1094.
10. William S. Sadler, *Theory and Practice of Psychiatry* (St. Louis: The C. V. Mosby Co., 1936), p. 811.
11. Henderson and Gillespie, *op. cit.*, p. 268.
12. *Ibid.*, p. 267.

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PURE PARANOIA AND PARANOID STATES

In order to avoid confusion, it is essential to distinguish carefully between pure paranoia, paranoid states, and paranoid schizophrenia. The first and the last can be more or less accurately described, but paranoid states include a wide variety of conditions that have little in common with each other except pronounced delusions.

Pure paranoia is a grave mental disorder of psychogenic origin, characterized by a well-organized delusional system.

It is rightly called a "grave disorder," for pure paranoiacs may become really serious social problems. When thoroughly systematized delusions of persecution are prominent, as they are in the majority of cases, the patient quite often becomes socially dangerous.

Its psychogenic origin becomes apparent when careful study of pure paranoia reveals the total absence of organic or toxic etiology. The same examination shows that psychological causes are chiefly responsible for its inception.

It is true that physiological and organic conditions are often characteristic of certain phases of psychotic states. However, in pure paranoia they are entirely absent; or, if present, are totally unrelated to the disorder itself.

The characteristic feature of the pure paranoia is the well-developed, highly organized delusional system. Ordinarily these are delusions of persecution, but sometimes delusions of grandeur hold the foreground.

Paranoid schizophrenia has already been defined and described. In the paranoid variations of schizophrenia, emotional apathy and indifference are the principal features. Delusions of persecution or grandeur are superimposed on this background, but tend to be unsystematized, transitory, and bizarre.

Paranoid state is a term used to designate a variety of conditions other than pure paranoia or paranoid schizophrenia, in which the delusional system is secondary or incidental to other abnormal conditions. Kraepelin coined a term for it—"paraphrenia"—but this nomenclature has not been widely accepted. Paranoid neurasthenia, paranoid variations of manic-depressive psychoses, paranoid senile

psychoses are frequently observed. Such states are other recognizable psychoses with a strong delusional content. They are designated as "paranoid," i.e., resembling true paranoia in the one regard that delusions play a prominent part.

HISTORY OF PARANOIAC DISORDERS

In the original Greek, the term *paranoia* meant "a condition of being disturbed mentally" or "of being intellectually warped." "Paranoia" was originally employed to signify the condition of being "beside oneself mentally," the condition or state of insanity, craziness, madness, or psychic infirmity. The disorder existed in all countries and was described in each country by terms easily understood in that locality. As a result, psychiatric literature offers a multiplicity of names for the same entity. In an interesting study made in 1894 by Cramer, we are told that as many as twenty-eight different meanings were given to the word "paranoia" at that time.

Plocquet, in 1772, included paranoia under delirium. Heinroth, who divided mental diseases on the basis of intellect, will, and feelings, treated paranoia as a disease of the intellect. Heinroth used the word *Verrücktheit* to convey such meanings. This was also the term used by Kraepelin in 1893 to signify pure, true, or genuine paranoia.

In 1844 Fleming recognized the existence of paranoia when he mentioned the paranoid form of "mania adstricta." By this he meant monomania, or a disorder of just one element. This is practically a synonym for pure paranoia, which is limited to systematized delusions. Fleming's contemporary, Stark, refers to paranoia under the word *Wahnsinn*.

In 1845 Feuchtersleber spoke of fixed delusions which affect the entire personality and of monomania, or mania *sine delirio*. All such psychic entities were looked upon as having in them certain elements pertaining to paranoia.

Griesinger, discussing mental disorders, used the term "*Verrücktheit*" which Einroch had used in 1818. According to Griesinger, this was an incurable condition exhibiting delusions of grandeur and persecution. This disorder, however, according to him, has its origin subsequent to an attack of mania and melancholia. In 1863 Kahlbaum used the word "paranoia" and considered it a "disease" of the intellect.

In 1881, Mendel spoke of the paranoia and divided them into primary and secondary. Those classified as primary would seem to be identified with what today is looked upon as pure paranoia. He

described them as a functional psychoses characterized by the primary appearance of delusional ideas. These delusions controlled the entire mental life of the patient.

Contrary to present findings, seventy-five years ago a large percentage of patients in mental hospitals were diagnosed as pure or true or genuine paranoiacs. Kraepelin stated that 70 to 80 per cent of all patients in the German mental hospitals were so diagnosed. This indicates that the syndrome for paranoia was then by no means definite. It seemed to have been the catchall into which all patients for whom no diagnosis was immediately available were tossed.

Thanks are due to Kraepelin for having systematized our ideas concerning paranoia. In 1893 he included paranoia proper or *Verrücktheit* in one of the divisions he made of mental disease. This *Verrücktheit* he defined as: "The chronic development of a permanent delusional system with complete preservation of consciousness." Today this is considered pure paranoia.

In 1899 Kraepelin added the "paranoid form" to schizophrenia. Hebephrenia and catatonia had already been described.

At the same time he reserved a small group which he classed as genuine paranoia. He described it as a condition in which mental clarity was preserved except for a gradual development of systematic and irremovable delusions.

In the eighth edition of his book, in 1913, Kraepelin described the paraphrenias. These stood midway between the paranoid schizophrenics and the pure paranoids. Kraepelin divided paraphrenia into four forms: *systematica*, *expansiva*, *confabulans*, and *phantastica*. Many have identified paraphrenia with paranoid conditions. The term "paraphrenia" is no longer used. Its place is generally taken by "paranoid conditions."

ETIOLOGY OF PARANOIAC DISORDERS

Incidence

Pure paranoia is a rare mental disease. Less than 2 per cent of the annual admissions to hospitals belong to this category. Many thousands may be admitted before a single case of pure paranoia is met with. Despite the relative scarcity of the disorder, it should be carefully studied because it helps one to understand the numerous paranoid conditions allied to it.

It is of special interest, too, because of its obvious nonorganic origin and the unique absence of all but delusional symptoms. Pure

paranoiacs often possess excellent intellectual powers and skillfully avoid being certified as psychotics. Formerly it was thought that the greater majority of pure paranoiacs were men, but it is becoming increasingly clear that females are also affected. The onset of the disorder in most cases takes place during the thirties, rarely before that time, and frequently later.

The extent of *paranoid states* (conditions, trends) is not known, but they are very common. The time of onset and other characteristics differ greatly according to the classification to which it is related.

Psychogenic Origin

This disorder is unquestionably one of psychogenic origin. The total absence of anatomical findings and signs of physical degeneration in paranoiacs are strong indications of the lack of organic basis.

The majority of modern psychiatrists consider it to be a type of personality disorder resulting from long-time indulgence in defective mental mechanisms, especially of compensation or projection or both.

Freud offers the opinion that paranoia is the result of habitually repressed homosexual urges.

Older psychiatrists have felt at times that heredity was an important genetic factor. This opinion is unsubstantiated and has now little or no acceptance.

A most important contribution to the appreciation and understanding of the paranoiac has been made by A. Meyer. He indicates that the key to understanding him is insight into the type of "constitution" developed by the patient. Constitution is here understood as the personality of the individual. He stresses the importance of prepsychotic traits, the fact that these traits have developed over a long period of time, and that the evolution of the paranoiac mind is a gradual process. His carefully established opinion that paranoia is clearly a disease of psychogenic origin has achieved wide acceptance.

The following hypothetical picture of the gradual development of a paranoiac illustrates how the process probably develops from its psychogenic origins.

Often from early childhood days, the potential paranoiac seems to suffer reverses from his environment. He possesses poor skill for making the necessary social adjustments. Soon he becomes touchy, sensitive, unreasonable, stubborn, moody, sulky, selfish, jealous, and envious. He becomes resentful of even the gentlest domestic regulation of his conduct. He realizes how he has failed and becomes

progressively more shy, reserved, self-conscious, and introspective. He is often inordinately ambitious. Failures are obviously unavoidable, as a result he then develops feelings of inferiority, lack of self-confidence, and finds it hard to work with others, to recreate with others, to be sociable. Continued contact with life and people and happenings further deflate his ego and increase his sense of inferiority. He continues to blame the environment and his health for his failures and develops hypochondriacal trends. He becomes irritable, quarrelsome, and worries about what others are thinking and saying of him. Many of his failures are delusional. The paranoiac begins to brood and to be vexed. There is a consciousness of shame, of suppressed feeling, and a more conscious realization of his inadequacy. Ideas of failure obsess him. There is but little real humility in his life, despite his reverses and inferiority complex. On the contrary, he becomes suspicious of others and regards them as the cause of his failure. To admit to himself that he is the complete cause of his real or imaginary failure would crush him. To blame environment and health affords him inefficient and unhealthy escape from his plight. All his mental mechanisms rapidly become defensive and compensatory in nature.

Most men have this tendency to explain away their failures, but the paranoiac is adept at projecting his mistakes on others. He develops habits of suspicion and jealousy, feelings of inadequacy, unpopularity, bitterness, and resentment. He becomes the victim of brooding, fixed ideas, obsessions, and fleeting daydreams of success.

This process will gradually undermine his personality. Little by little he fixes the source of his unhappiness and failures not on himself, where it belongs, but on others—his friends, relatives, business associates, or fanciful creations of his own imagination.

SYMPTOMS OF PURE PARANOIA

1. *The onset of pure paranoia is always insidious* and characterized by increasing evidence of touchiness, suspicion, jealousy, and inordinate ambitions. Such changes may develop slowly over a period of many years.

2. The outstanding characteristic of pure paranoia is the presence of *well-systematized and unchangeable delusions*. Delusions have been unsatisfactorily defined as false beliefs. They are more accurately described as: *false judgments, which are not subject to correction, and which are completely out of harmony with the individual's objective environment and status*. They are *false judgments*, i.e., contrary to

facts. For example, a patient will complain, "I am being chased by policemen," when no policemen are in evidence, or "I am the Queen of Holland," when the objective reality indicates that such is not the case. It is clearly an act of the intellect or mind.

False judgments are frequently made by normal people, but when *they are not subject to ordinary corrections*, the state of mind is delusional. That is, when the one making the false judgment is not able to understand or accept overwhelming evidence which clearly in the mind of everyone else disproves his own judgment, his mental state is one of pathological delusions.

The delusions of the pure paranoiac are *highly systematized and well knit*. If the premise or foundation of the delusion could be granted, the rest of his story would often be very logical and coherent. It is true that delusions are found in many psychotic states and at times they may come and go or change frequently. But in the pure paranoiac they are *unchangeable*. This is the outstanding symptom of the disorder.

In the pure paranoiac, the closer his condition approaches its final stage of development, the *less is the likelihood of mental deterioration and personality dilapidation*. Most paranoiacs may maintain correct insight, good memory, and clear judgment in matters not pertaining to their delusions.

Hallucinations do not occur in pure paranoia.

There is much clinical evidence to indicate the *importance of the prepsychotic personality* in cases of pure paranoia. There is no special type of development that inevitably leads to paranoia. Patients with the disorder frequently present a history which reveals habits of jealousy, hypersensitivity, suspiciousness, egocentricity, and inferiority feelings. Such dispositions provide fertile soil for the development of many types of psychoses. They also may play an important role here. In some cases there is apparently no significant prepsychotic history, but this deficiency is most probably more apparent than real. The following case history will help to bring out the nature of the condition.

CASE 41: Pure Paranoia

A lawyer, aged 40, was brought for observation on the complaint of his wife. An examination of family history yielded negative results. Personal history indicated normal birth and early development. He graduated from college the highest in his class, and was a brilliant scholar. There had been no serious illnesses or injuries. He was married and had three children, all living and well. He had been a

temperate drinker and used no drugs. Once before, he had been tried before a sanity commission on the complaint of his wife, who stated he threatened many times to kill her. He was released as sane, however, and continued a successful practice. The onset of the present illness occurred more than ten years ago, when the patient became suspicious of his wife. He accused her of entertaining men friends in his home while he was at the office. He frequently threatened to kill her, stating that she was unfaithful to him. Attempts to have him committed were unsuccessful, as the patient denied every allegation by his wife when confronted with the accusations in court. Upon his return home, he continued to entertain the persecutory ideas against his wife.

Exteriorly he presented a picture of a brilliant, charming, and kindly gentleman. He was very fond of his children and at no time revealed to them his antagonism to his wife. She repeatedly endeavored to obtain a decree of commitment, but the patient skillfully frustrated these efforts. Finally, however, he was judged insane and committed. At the hearing, he accused his wife of illicit romance with another man and said that she had confessed to it. She carried poison on her person with the intention of killing him. The Masons persecuted him. Friends plotted against him. The wife was accused of being indiscriminately intimate with all these persecutors and of operating a house of prostitution. He threatened to kill her and all his enemies.

In the institution he was a model patient — alert, energetic, cheerful, and co-operative. He was extremely resourceful, and by skillfully employing his legal knowledge, twice succeeded in obtaining a release from the institution. Each time the delusions with regard to his wife and friends asserted themselves. This state of affairs endured for about twelve years. He finally collapsed physically and mentally one month before his sudden and unexpected death.

The case just cited relates the story of a pure paranoiac. The highly developed and well-organized delusion of persecution was the main constituent of the disorder. Most of the victims of pure paranoia are dangerous because of their superior intelligence. The perpetration of some grave crime dictated by their delusion is sometimes the only grounds for obtaining commitment.

PARANOID STATES

Many cases of paranoid insanity closely approach pure paranoia. There is, of course, no hard and fast line of distinction between them, but there are differences.

In the paranoid states hallucinations are noted; they are extremely rare or entirely absent in pure paranoia. In the former states there is also greater disintegration of personality, less contact with reality, less well-systematized delusions, and frequent changes of delusional content. The differences between the two are often not very profound or marked.

Many other paranoid states clearly belong to other groupings such as manic-depressive psychoses, the involuntional states, and psychoses with organic features. The classification is determined by the underlying and dominating type of personality. The delusional states are a secondary or a more or less accidental characteristic of the syndrome.

CASE 42: *Paranoid State*

The family history of this 62-year-old female was negative. Her early history was normal. She had always been strong and healthy. She had a high school education and had been a good student. She married at 15, and had three children. She passed through the menopause at 51 without difficulty. Her husband died in 1918 and since then she has lived alone and made her living as a housekeeper. The onset of her present illness is indefinite. The patient is said to have been peculiar for years. About one year before admission she became homicidal and entertained many ideas of persecution, directed in particular against a man named "Casey." Auditory and visual hallucinations were marked. She heard people under the floor of her apartment, heard people talking to her whom she could not see. She thought the man "Casey" was at the bottom of her persecutions. He had "secret doors to her apartment." The people under her floors bothered her day and night. She stayed in her room all the time and was afraid to open it to anyone. She got up at midnight, hammering on the doors, and using profane language. She talked to herself and threw things about the floor. The neighboring occupants became fearful of her when she threatened bodily injury to them, and they filed a complaint against her. When the sheriff called for her, she refused to open the door, until she was told it was the mailman. He found everything in the room packed and a loaded revolver on the table. She became violent and abusive. She was thereupon committed to a hospital. Here she demanded to see her attorney, stating a large fortune had been left to her, but that people about her had cheated her out of her inheritance. She said they called her foul names. She admitted threatening Mr. "Casey" with a loaded revolver when he came to collect her rent. She thought he conspired against her. She reiterated that she heard people talking

under her floors, speaking disparagingly about her and making slurring remarks. She said people stuck their noses under the seats in movie theaters, telling her to get out. She smelled queer odors. She was indignant when she discussed her court hearing. She claimed she was from a very highborn family and that it was absurd, under these circumstances, for them to think her insane. Her sensorium was intact. There was no marked impairment in the intellectual field at the time of admission. The patient was suspicious, exalted, and had a grandiose air. Delusions were fairly well fixed and systematized.

PROGNOSIS

The prognosis of pure paranoia is very poor. It is doubtful whether the condition, once developed, ever disappears.

TREATMENT

The majority of pure paranoiacs do not reach hospitals. When they become dangerous, commitment is necessary. The prognosis is practically hopeless. There is no specific treatment. Psychotherapy has value in its early phases.

In paranoid states and in paranoid schizophrenias the treatment of choice is insulin shock therapy or electroshock therapy; however, as indicated in the section dealing with electroshock, these conditions do not always respond well to such therapy, and prolonged institutional care is usually necessary.

SUMMARY

Paranoia is the least common of the psychoses. It is characterized by a well-organized delusional system in which it differs from paranoid conditions in which the delusional system is less well organized. Hallucinations do not occur in paranoia. In paranoia the delusional system is so intact that it can all be upheld by rather logical proof. It is only the initial premise which is wrong. There is no satisfactory treatment of paranoia.

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TOXIC PSYCHOSES

INTRODUCTION

Toxins are of two types: (1) exogenous, (2) endogenous.

1. *The exogenous poisons are developed outside the body and absorbed by it. The principal exogenous toxins, from a psychiatric point of view, are those derived from:*

- a) Alcohol
- b) Opium and its derivatives, morphine, and heroin
- c) Cocaine
- d) Marijuana
- e) Lead
- f) Gas

2. *The endogenous toxins usually arise during the course of acute infections or somatic diseases and as a rule are bacterial in origin. The main endogenous toxins, from the point of view of mental disorders, are:*

- a) Those arising because of malfunction of the endocrine glands, particularly the pituitary, thyroid, and adrenals;
- b) Those found in connection with acute infections;
- c) Those resulting from somatic diseases, such as uremia.

SYMPTOMS COMMON TO ALL TOXIC PSYCHOSES

The symptomatic pattern in all the toxic psychoses is very similar and consists of:

- 1. Disturbance of consciousness, which may vary from slight clouding to complete delirium;
- 2. Marked disturbances of the sensorium;
- 3. Increased psychomotor activity;
- 4. Disorientation;
- 5. Vivid hallucinations.

EXOGENOUS TOXINS

*Alcohol*1. *Social Drinking*

No attempt is made in this chapter to discuss any of the aspects of alcohol which may be reduced to purely social drinking. Social drinking is indulged in because of the individual's wish to ease tension, to relax after a day's work, to enliven the flow of conversation, or to affect partial oblivion for the unpleasant happenings of the day. Social drinkers, and their name is legion, may never even remotely become alcoholics. They usually know when to stop drinking.

2. *Chronic Alcoholism*

Incidence. It is estimated that about forty million people use alcoholic beverages in this country. About three million of these are considered to drink more than the average amount and are likely to become psychiatric problems. It is further estimated that there are about seven hundred and fifty thousand chronic alcoholics, most of whom are not in institutions. In 1910, it was estimated that about 10 per cent of first admissions to hospitals were due to alcoholic disorders. By 1920, this number had dropped to 2 per cent. In 1930, it had again increased to around 10 per cent and has shown a gradual rise since that time.

The age of onset. Obviously there is no particular age at which alcoholic disorders are likely to appear. Some patients develop habits of excessive use as early as 18 years of age, or even younger. The psychoses due to alcohol are not likely to occur until past middle age.

There is no proof that excessive use of alcohol is a trait transmitted by heredity. If we can regard parental example, early home training, and an inadequate philosophy of life as evidence of a social heredity, then the condition is frequently acquired from the parents. According to the present theories, the excessive use of alcohol is an acquired trait, and, as such, is not subject to hereditary transmission.

It may be well to observe in this connection that there is no demonstrable state of body or mind which can compel the normal man to drink excessively. Chemical craving does not explain why men must drink.

Alcoholism is of psychogenic origin. Until recently no satisfactory concept of the etiology of overindulgence in alcohol had been formu-

lated. It was ascribed to a number of vague factors, among which were such terms as "constitutional predisposition." The popular concept of the alcoholic was a boisterous, cheerful, "hail-fellow, well-met," who, when under the influence of alcohol, although at times belligerent, was on the whole a good-natured fool. Much of this previous misinformation came about as a result of a failure to regard alcoholism as a psychic disorder.

The problem at hand is to explain how this disorder, this psychoneurosis, alcoholism, takes possession of the personality of the individual. The answer to this question would account for the etiology of alcoholic psychoses. There is probably no explanation which would fit all cases of chronic alcoholism. The most frequent common denominator is a strong sense of inferiority especially in social contacts. There may be no single basic conflict but more likely a series of deflating experiences.

Profile of the chronic alcoholic. The average chronic alcoholic is an emotionally immature but frequently intellectually brilliant individual. This individual may be either male or female, but is most frequently a male. By the very nature of his disorder he is selfish, thinking first of his own feelings, and giving but little consideration to those near and supposedly dear to him. Without too much struggle, he relinquishes the honor and respect which he owes himself as a person and accepts the narcotic influence of alcohol as an escape from his feelings of inferiority, which so frequently haunt him. His introverted personality welcomes escape into imagery in which it indulges with increasing frequency. His strong feelings of inadequacy and inferiority continue to create conflict and each new social contact calls for further narcosis. He retains sufficient insight, and so his own recognition of the inadequate method of solving his conflicts drives him more deeply under the narcotic influence of alcohol which is his only escape.

Under the influence of alcohol there is for him no introversion, no bashfulness, no inferiority complex, and no critical sense. He feels no social strain and acts as though he had from all quarters secured the most cordial social acceptance. He has daring, courage, and strength. While under the influence of liquor, his approach to life is but semirational and his insight and judgment are practically nil.

At a physical level alcohol lessens control and by depressing the ability for critical thinking and self-evaluation helps to deaden the awareness of conflict. The need for alcohol is thus created by the

viewpoint of the individual. Alcoholism is, therefore, a psychogenic help to escape from an ill-organized self and from unsolved problems.

The same idea is given by Goodman and Gilman. Discussing the alcoholics, they say:

The psychic phenomena which follow the ingestion of alcohol arise from an inhibition or depression of higher mental processes, especially those depending on training and previous experience and which usually make for sobriety and self-restraint. The finer grades of discrimination, memory, concentration and insight are dulled and then lost, impulsive speech and actions result, and inhibitions are removed. Confidence abounds, the personality becomes expansive and vivacious, and speech may become eloquent and occasionally brilliant. Mood swings are uncontrolled, and emotional outbursts frequent. The individual may believe himself powerful enough to whip several strong men even when it takes this number to hold him upon his feet.¹

Alcoholism an escape mechanism. Alcoholism is an immature and an inadequate escape from a conflict. Unlike the manic-depressive psychotic who in the presence of his conflict becomes alternately excited and depressed, and unlike the schizophrenic who regresses to images when life's cares oppress him and weigh him down, the alcoholic in the presence of his unbearable conflict renders himself dazed, insensible, narcotized, and paralyzed. Alcoholism is, therefore, psychogenic in etiology, and is the end result of an ill-conceived and ineffectual attempt to escape life's conflicts.

Jelliffe and White² look upon alcoholism as being psychogenic. They observe:

When the individual is confronted by situations to which he cannot adjust adequately, when the world of reality makes demands which are too great for him to meet, one of the ways in which the individual reacts to such a condition is by narcotizing himself and so withdrawing from the whole situation. Alcohol then becomes an agent which helps the patient to get away from the conflicts thrust upon him by reality; it helps him to withdraw within himself, helps him to live in the world of fantasy where things come true as he wished them.

Under these circumstances it can be seen why what appears to be a habit is formed. The moment the individual, harassed by the absolutely unacceptable demands of the world, finds the possibility of peace and repose, he finds that it is equally impossible to resist the temptation to avail himself of alcohol and, of course, he usually continues to avail himself of it. He is rendered more and more incapable of meeting the conflict efficiently.

Therefore, a vicious circle is established and the individual is hopelessly involved. From this psychological point of view, alcohol is seen to be an agent that breaks down sublimations and permits regressions. The drinking of alcohol is, therefore, a concession to the demand for regression and the acute alcoholic psychoses are thus more properly of psychogenic rather than of toxic origin. Alcohol in this sense can hardly be considered a toxic agent at all. This concept of the action of alcohol is borne out by the fact that not infrequently the same symptoms that led to the diagnosis of an acute alcoholic psychosis have been seen to supervene without alcoholic indulgence.

The same point of view, that alcoholism is psychogenic, is also presented in the *Scientific Temperance Journal*, which maintains that men become alcoholics

- a) As an escape from situations of life which cannot be faced;
- b) Because of a maladjusted personality;
- c) Through a development from social to pathologic drinking;
- d) Because of a major abnormal mental state, such as a depressive or schizophrenic reaction of which alcoholism is a symptom;
- e) As an escape from incurable physical pain;
- f) Because of a psychopathic personality, one with constitutional inferiority.

According to many psychiatrists, individuals overindulge in alcohol because

- a) It narcotizes or deadens the sense of conflict;
- b) It gives them a sense that they are socially competent;
- c) It facilitates fear adjustment by giving them the feeling of well-being and of success;
- d) It compensates for rebuffs received;
- e) It affords an escape technique from conflicts or at least proposes a method for sidetracking them;
- f) It permits one to become oblivious concerning his unsolved conflicts which resulted from his poorly organized personality.³

In short, we say that *alcoholism is a psychoneurosis*.

The present concept is that chronic alcoholism is a psychoneurosis. The chronic alcoholic is much more likely to be an introvert than extrovert. His boisterousness and his good-fellowship appear only when he has enough alcohol in his system to elevate him above his feelings of inferiority. He drinks to escape either from his problems or from his feeling of inferiority. Although the individual drinks at first to escape from the dull monotony of the daily routine, he later

develops the habit of drinking more and more as he discovers that under the influence of alcohol he is able to escape from his responsibilities. The best definition of the chronic alcoholic is undoubtedly that given by Strecker: "The chronic alcoholic is the person who cannot face reality without alcohol, and yet whose adequate adjustment to reality is impossible so long as he uses alcohol."⁴

3. *The Alcoholic Psychoses*

Alcoholic psychosis may be defined as grave mental disorder found in connection with excessive use of alcohol which was imbibed because of defective personality integration and resulting unsolved conflicts.

The official classification describes alcoholic psychoses as follows:

Under this heading are to be grouped only those cases that have abnormal mental reactions which can reasonably be concluded to have alcohol as the etiological factor. Excessive alcoholism may be a symptom of some other psychosis or some other psychopathological condition or, on the other hand, it may aggravate or bring to notice an already existent psychosis of a non-alcoholic nature. Such cases are to be carefully distinguished by the previous history, by the symptomatology and course, and should be grouped elsewhere under their proper categories.⁵

Classification. The alcoholic psychoses are usually divided as follows:

- | | |
|------------------------------|----------------------------|
| a) Pathological intoxication | e) Alcoholic deterioration |
| b) Delirium tremens | f) Alcoholic paranoia |
| c) Alcoholic hallucinosis | g) Dipsomania |
| d) Korsakow's psychosis | |

a) Pathological intoxication

Definition. Pathological intoxication is an acute alcoholic psychosis in which the individual reacts to the ingestion of even small amounts of alcohol with violence, delusions, or hallucinations. It is usually followed by a profound sleep and amnesia for the attack.

Etiology. This type of violent response to the ingestion of alcohol occurs most frequently in those individuals who are under great emotional stress. The lowering of inhibitions by the ingestion of alcohol allows this intense emotion to escape explosively. Under these circumstances, hostility, if present, may be directed violently toward its source.

Symptoms. The symptoms may follow the ingestion of either a small or large amount of alcohol, depending on the drinking habits of the individual. As a rule, the patient becomes suddenly confused,

overactive, combative, and destructive. He is disoriented and is likely to demonstrate profound emotional disturbances of depression, despair, or anxiety, and under their influence may attempt either suicide or homicide. The acute episode usually terminates with profound exhaustion and sleep. Amnesia for the attack is usually present.

b) Delirium tremens

Definition. *Delirium tremens is an acute psychosis usually occurring after prolonged, excessive use of alcohol, or following deprivation of alcohol in one accustomed to its use.* It is characterized by tremor, delirium, confusion, hallucinations, and by an amnesia for the attack.

Etiology. Although the exact etiology of delirium tremens is undetermined, it occurs most frequently in chronic alcoholics following prolonged overindulgence. It is also frequent in chronic alcoholics who for some reason are deprived of their daily intake of alcohol. It is likely that Vitamin B deficiency also plays a part, since the alcoholic on a prolonged spree seldom eats properly. Pathologically, the most common finding is edema of the brain.

Symptoms. The onset of the condition is usually sudden and characterized by a rapidly progressive restlessness, agitation, anxiety, and loss of interest in the environment.

As the condition develops, the patient becomes tremulous, disoriented, and hallucinated. These hallucinations are usually visual in nature and very real and terrifying to the patient. As a rule, the hallucinations are zoological in character, and colored. To the patient, his "pink elephants" and "purple snakes" are real and terrifying. He tries to brush them aside or attempts to hide under the covers to escape from them.

Exhaustion, due to terror, lack of food and sleep, eventually results.

Prognosis. With proper treatment, prognosis is favorable. About 85 per cent of the patients recover from their delirium. Five to fifteen per cent die of intercurrent disease or exhaustion.

CASE 43: Delirium Tremens

On admission to the hospital, this 54-year-old white male was disoriented for time and place. His comprehension and attention were impaired and he had a complete amnesia for the last few days before admittance. He did, however, admit excessive drinking for an indefinite period, and gave evidence of vivid hallucinations. On examination there was a gross tremor of the hands, thickened, indistinct speech, evidence of hallucinations, and fright.

Information from the family revealed that he had been drinking excessively for the past five years, usually going on periodic sprees. He had been arrested at least twice because of intoxication, and just prior to his admission to the hospital he had been arrested again because he had entered a girl's hotel room and frightened her.

Shortly after admission, he became more tremulous and agitated. His hallucinations became more terrifying, and he divided his time between trying to chase away a variety of colored animals and hiding from them under the covers.

Eight days after admission he was considerably improved and was able to carry on a coherent and relevant conversation. He had very little recollection of the events leading up to his hospitalization.

c) Alcoholic hallucinosis

Definition. Alcoholic hallucinosis is an acute or chronic psychosis which usually appears after prolonged or excessive drinking. It is characterized by a relatively clear sensorium, little affective disturbance but extremely vivid hallucinations.

Symptoms. Clinically the outstanding manifestation of this condition is the presence of vivid hallucinations which may be either auditory or visual. As a general rule, the patient is quite lucid; correctly oriented for time, place, and person; and has an accurate and correct memory and may even be able to express himself with skill and eloquence. The hallucinations are frequently offensive and disparaging. The patient accepts his symptoms as real and may build upon this basis a well-systematized set of delusions. In many instances the hallucinations may be of a more benign character and are accepted by the patient with little affective disturbance. On recovery the patient can usually remember what has happened and may still accept it as factual.

CASE 44: Acute Alcoholic Hallucinosis

This white male, age 37, when first seen, was perspiring freely, but did not appear to be in any distress as he sat up in bed. At the time of the examination, he was five days postoperative. He was well oriented in all spheres at the time. He stated that he had just returned from the dining room where he had seen a chipmunk which he admitted was not usually to be expected in a hospital, but which probably came in because of the proximity of the hospital to the woods. According to the patient, the unusual feature of this chipmunk was that he talked, or at least repeated things which were said to him. The patient stated that the previous night he had gone out

to dinner. He claimed that on the previous afternoon he saw a parade "back there" which was composed of soldiers carrying tree branches which were in the shapes of animals. He described it all in a factual manner. A few days later, the patient had a clear sensorium and a complete amnesia for the events of his delirium.

d) Korsakow's psychosis

Definition. Korsakow's psychosis is a chronic psychosis due to the prolonged use of alcohol, characterized clinically by peripheral neuritis and retrograde falsification of memory.

Etiology. Although at first the condition was thought to be due to alcohol, it is now believed that it results primarily from the restriction of the patient's diet which occurs while he is drinking, and that the degenerative changes are due to a prolonged dietary deficiency.

Symptoms. Physical examination reveals evidence of a multiple peripheral neuritis with considerable pain and tenderness along the course of the nerves. As the condition progresses, various paralyses may result. The most common of these are "Wrist Drop" and "Foot Drop." The "Foot Drop" is quite likely to result in a "steppage gait." In the affected extremities the tendon reflexes are absent.

On mental examination, the outstanding manifestation is the memory defect for recent events. Because of this loss of immediate memory the patient confabulates, or has retrograde falsification of memory. He gives vivid accounts of events which did not take place, or which are inappropriate to his state in life. Although superficial examination seems to indicate a clear consciousness, further study usually reveals confusion, disorientation, lack of insight, and both intellectual and emotional deterioration.

Prognosis. In the less severe cases, recovery can be expected under appropriate treatment in from four to twelve weeks. In these cases the personality is likely to be well preserved. In the majority of cases, however, especially in those showing severe nerve damage, although the symptoms may disappear, the condition leaves a permanent scar.

e) Alcoholic deterioration

Definition. Alcoholic deterioration is a dementia resulting from organic brain damage which occurs following prolonged, excessive use of alcohol.

Symptoms. The symptoms are similar to those of any diffuse brain damage. There is emotional blunting, defective memory, emotional instability, poor judgment, and lack of insight.

f) *Alcoholic paranoia*

The paranoid type of alcoholic psychosis is most likely to develop in those individuals who have previously had a paranoid personality. It is characterized clinically by the presence of poorly systematized delusions usually in regard to marital infidelity which frequently result in dangerous, even homicidal, behavior.

Etiology. The development of the paranoid personality has been previously discussed. Paranoid delusions usually occur in those people, who from their earliest years have persistently found fault with others and projected the blame for their own faults on them. They are suspicious and believe that everyone is against them. The delusion of infidelity, which forms such a prominent part of this complex, frequently arises when the affected individual discovers that he is impotent. He suppresses this crushing blow to his ego, but by way of compensation develops delusions of jealousy and infidelity on the part of his wife. Although homosexuality is usually stressed as the principal cause of the paranoid trend in alcoholics, it seems to us that, although this factor may play a part in a few cases, it is absent in the majority.

Symptoms. Poorly systematized delusions are the principal characteristic of this condition. Hallucinations are absent. Even when sober, the patient may have difficulty in keeping his delusions under control. Many of those so affected are above average in intelligence.

g) *Dipsomania*

Definition. *Dipsomania is characterized by a periodic impulse to drink. In the intervals between such impulses there is no desire for alcohol.*

Etiology. It seems likely that the recurring tendency to drink in these patients arises from a neurotic desire to escape from reality, or as a means of release from depression which arises as a result of an unhappy environment.

CASE 45: Dipsomania in a Psychopathic Personality

This 38-year-old white male laborer was admitted for observation at the insistence of his wife and a welfare agency. He stated that he was a periodic drinker and during his periods of drunkenness he was told that he was combative and expressed delusions of jealousy. The patient, his wife, and seven children lived in a crowded, poorly furnished three-room apartment. Their income had always been marginal, and they had lived at a subsistence level. The patient had disliked school intensely and was frequently truant. He left school to go to work at the age of 13, but since that time had never

held a job more than a few months at a time because of his drinking. He had been arrested a number of times for drunkenness and fighting. When he was drinking, he was irritable, had a violent temper, was unreliable and abusive, particularly toward his family. During his brief periods of sobriety he was, on the contrary, reliable, kind to his wife and children, and quite docile. He displayed little interest in his environment and seemed to have no aspiration except his immediate comfort. He quarreled frequently with his wife over his alcoholism and beat her regularly, when intoxicated, because of alleged infidelity.

Treatment of alcoholics in general. The treatment of alcoholism is divided into two parts: (1) acute alcoholic intoxication, (2) chronic alcoholic intoxication.

Acute alcoholic intoxication. This does not differ from the treatment of acute intoxication resulting from other causes and is concerned principally with (a) the elimination of the toxic agent as rapidly as possible; (b) the maintenance of nutrition while this is being done; and (c) the protection of the patient during his period of confusion and delirium.

Chronic alcoholic intoxication. The treatment of chronic alcoholism has been little understood. It is only in recent years that any serious effort has been made to understand the psychopathology of the chronic drinker. Basically, most alcoholics are introverts, their drinking very frequently is done in an effort to bring them up to the social level of their confreres. Alcoholics are selfish, self-centered, arrogant, lacking in insight. They are usually the "be-all" and "end-all" of their own existence. They are readily tolerated by society, though of themselves they are weak and ill-organized citizens. Alcoholism provides them with an escape from their conflicts. For this reason it is extremely important that a careful inventory be made of the personality of the patient, and immature and incorrect attitudes should be corrected.

In most cases, prolonged hospitalization is advised in the treatment of alcoholics. During this time the patient can become thoroughly desaturated, and also during this period an effort should be made first by suggestion and later by re-education to make him meet reality and to accept a sound philosophy of life. In this latter regard the following points should be stressed:

- 1) Man's nature, stressing his intelligence, free will, and consequent responsibility;
- 2) The goal of man, immediate and ultimate;

- 3) The norm of morality (right and wrong) and man's obligation to live virtuously;
- 4) Formation of principles, habits, ideals, and character;
- 5) The difference between sensory and rational cravings;
- 6) The necessity of a proper subordination of sense urge to reason and to man's ultimate goal.

In light of the knowledge derived from the consideration of the above points the alcoholic should clearly grasp the nature of the immature motives that lead to his overindulgence. He should be convinced that he is at his best while sober, that dependence on alcohol paralyzes his higher powers and reduces him to the level of the beast. It should be made clear to him that alcoholism affords no real solution to a conflict, but merely begets new and deeper ones. It should, of course, be borne in mind that after prolonged overindulgence the factor of habit enters in, so that the drinking may continue as a habit long after the original causes of the disorder have disappeared. He may never attain the psychic strength which will enable him with safety to become a social drinker. He should, therefore, resolve to follow total abstinence. Alcohol, though not in itself evil, has become for him something entirely dangerous and to be avoided.

When a person sincerely attempts to overcome alcoholism he should never be discouraged. The Alcoholics Anonymous in the *A.A.* of March, 1945, claim to have a total reformed group of 15,000 ex-drinkers.

The Twelve Steps of Alcoholics Anonymous are as follows:

1. We admitted we were powerless over alcohol — that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God, "as we understand Him."
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.

11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual experience as the result of these steps we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Prognosis. If the alcoholic is truly serious the prognosis is good. He will then avail himself of all means, physical, psychological, and spiritual, necessary to amend his life.

There is, however, a grave danger of relapse under stress of conflict, for the alcoholic has formed tenacious habits of regression in the face of difficulties. He has frequently narcotized his powers and found satisfaction in so doing. Without a complete reformation of life there is the gravest danger of relapse. The "alcoholics anonymous" that are cured, however, are the proof that a complete reformation of character and attainment of maturity are possible for alcoholics.

Drug Psychoses

1. Opium and Its Derivatives

Under this heading are listed those psychoses due to opium or its derivatives. The official classification (002-370) describes them as follows:

Here should be grouped those comparatively infrequent psychotic reactions appearing in habitual users of opium and particularly its derivative, morphine. Such effects appear to show themselves in mental deterioration when there is present demonstrable memory defects as well as an ethical and social deterioration. Paranoid states may also develop. Difficulty may be experienced in differentiating the actual effects of the morphine intoxication from the underlying personality defects which seem frequently to be present and which would place these individuals for statistical purposes rather in the group of psychopathic personalities. Drug addicts who do not show definite psychotic manifestations sufficiently to justify their hospitalization or their special treatment because of their mental condition should be classified not under this sub-group, but under the heading, "Drug Addiction" (000-3xxx).⁶

Etiology. The use of opium and its derivatives, particularly morphine and heroin, is employed as an escape from life's problems in very much the same way as is alcohol. Their use is less frequent than that

of alcohol because they are less available and because of the social stigma attached to their use. It has been estimated that 10 per cent of addicts begin their use of drugs while under medical care, and that another 10 per cent is taken from ranks of those to whom the drug is readily available, such as doctors, nurses, and druggists. The vast majority of addicts, however, are derived from those who have been initiated into the habit by companions who are themselves addicts.

It has been estimated that from seven to ten thousand tons of raw opium are produced annually. This exceeds the normal medical demand by at least 80 per cent. The exact number of opium addicts is not known. The number has been variously estimated at from five thousand to one hundred thousand.

The length of time taken to develop addiction and the amount of the drug needed for this purpose are subject to great variation. According to one estimate, addiction will develop in forty days or less on moderate dosage. In some sensitive individuals, addiction has been known to develop in a week.

2. Stages in the Development of Addiction

- a) Response to a therapeutic or toxic dose.
- b) Development of increased tolerance.
- c) Early addiction.
- d) Established addiction.

a) Response to a therapeutic or toxic dose

- 1) Since opium is narcotic, its first effect is to deaden the higher centers and thus give rise to an apparent mental stimulation and release from care and responsibility.
- 2) Relief of pain, whether physical or mental.
- 3) In larger doses, the imagination is stimulated with the production of pleasant reveries and delightful fantasies. This stimulation of the imagination produces a great ease in combining images with the danger that these may be mistaken for judgment and reason.
- 4) Euphoria usually results with a consequent disappearance of doubt and uncertainty. It develops a great belief in ability, and the patient is likely to be thrilled by the combined influence of his psychic and physical powers. This state is known as the "honeymoon" of addiction.

b) Development of increased tolerance

With continued use of the drug, the "honeymoon" is soon over, and

gradually increasing doses become necessary for the production of the euphoric state which the patient has come so greatly to desire. In the absence of much larger doses, the addict becomes aware of a growing inability to concentrate. His voluntary control over his mind and imagination, his senses and muscles, becomes increasingly more difficult. Muscular in-co-ordination is likely to occur. His intelligence becomes less keen and apathy gradually develops. At this stage, the withdrawal of the drug will cause temporary increase of these symptoms, but is not likely to produce any more serious results.

c) Early addiction

In this stage the individual has become definitely dependent upon the use of the drug, and if he does not receive it, will become restless, apprehensive, uneasy, irritable, and depressed. His appetite decreases and he may have no desire for food of any kind. Nausea and vomiting may occur. Various disturbances of the upper respiratory system may occur, such as inability to breathe through the nose, sneezing, yawning, and a free flow of tears. His skin may become cold and covered with perspiration. Muscular tremor and in-co-ordination may be pronounced. If the addiction is not severe, the symptoms are not likely to go beyond this stage and are apt to disappear after a few days.

d) Established addiction

In this stage, the need for the drug becomes much more imperative and its withdrawal for even short periods is likely to produce severe symptoms. Upon withdrawal of the drug, the symptoms described in the paragraph above are likely to be present for ten to twelve hours, after which the restlessness becomes more severe and the patient is likely to become uncontrolled. He has severe muscular cramps and soreness. He cannot be comfortable in any position and feels an extreme urge for the drug. At this stage, he is quite likely to sleep for a period varying up to ten or twelve hours. Upon awakening, his agitation is likely to occur in a severe degree for about five days and then gradually to decrease in severity up to the fifteenth day, when a subsidence of the symptoms is to be expected.

Prognosis. The best outlook for cure is in those persons who have become addicts as a result of medical treatment in which the drug was used for the relief of pain. In those individuals, however, who have used the drug because of the pleasant sensations which it produces, relief of addiction is not likely to be easy, and less than 20 per cent may be expected to show complete relief from their addiction.

Psychoses due to the use of opium. When a psychosis develops as

the result of the use of opium (and it is likely to occur in emotionally unstable individuals), it is usually of the hallucinatory type such as develops from the excessive use of alcohol. Schizophrenic reactions of a paranoid type are not unusual.

Cocaine

Cocaine psychoses are described by the *Statistical Guide* (002-345) as follows: "Here should be classified those cases which develop abnormal mental states in association with long continued, or brief excessive use of other drugs, such as cocaine, bromides, choral, acetanilid, phenacetin, sulphonol, trional and other proprietary combinations."

Cocaine is more likely to produce addiction than opium. It is most frequently taken by "snuffing."

Symptoms. Cocaine produces great stimulation in both the physical and psychic spheres. Under its influence, the creative imagination becomes overactive so that the images tend to be projected. A variety of wild schemes and plans are imaginatively thrown together and are likely to be acted upon. The activity is likely to become hypomanic or even manic in character. A marked feeling of euphoria occurs. Critical senses are dulled with a consequent lack of insight and judgment.

This intense state of activity, occurring in an individual who is not physically strong, soon produces fatigue and exhaustion. In this stage, the addict becomes lethargic, tired, and weak. His moral sense is dulled and he is likely to commit crimes or be guilty of perverted conduct. He becomes depressed, and his irritability and anxiety are in sharp contrast to his early elation. Repeated use of cocaine is necessary to avoid these secondary effects.

Withdrawal symptoms in cocaine addiction are not as severe as those following the use of opium, but permanent relief of addiction occurs less frequently with this drug.

Marijuana

Marijuana is also known as *cannibus indica* or *cannibus sativa*, the latter being the source of the official U.S.P. preparation. It is obtained from the flowering top of the hemp plant. It grows readily in many parts of the world, including the United States. Its narcotic effect may be obtainable either by smoking or chewing or by ingestion in a liquid form.

Symptoms. The effect of marijuana depends to a certain extent on the user's disposition and character. It may produce either excitement

or apathy. In psychoses resulting from marijuana, the clinical picture is likely to be one of an acute hallucinatory mania. The effects of the ingestion of marijuana may be listed briefly as follows:

- a) A dream state is likely to occur with clouding of consciousness, disorientation, and delirium.
- b) Incoherence of speech and thought.
- c) The emotional state, depending on the person's natural disposition, varies from euphoria to depression.
- d) Remote memory may be markedly stimulated.
- e) The passage of time seems markedly decelerated.
- f) The patient feels detached from his environment and even nearby objects seem far away.
- g) The imagination becomes extremely active.
- h) Inhibitions are lessened and loss of emotional control occurs with the commission of acts of violence.
- i) Hallucinations and delusions may occur.

Prognosis. Addiction does not occur with marijuana as it does with opium and withdrawal symptoms do not occur. Tolerance is not established, so that the same dose will continue to produce the same effect. Discontinuance of the drug depends on the individual's desire to do so, and his ability to control his craving for its pleasant effects.

Psychoses Due to Lead Poisoning

Psychoses due to lead poisoning are described by the *Statistical Guide* (002-310) as follows:

Here are to be grouped those psychoses due to prolonged exposure to metallic poisoning, particularly lead, arsenic and mercury. Persons so exposed often showing earlier gastro-intestinal and peripheral nerve toxic symptoms, may develop deliria accompanied by marked prostration from which they may recover, or they may be left with intellectual or emotional defects apparently based on encephalopathy associated with these toxic conditions. The clinical picture at times resembles the Korsakow's Syndrome.⁸

Poisonous fumes produced in some industries are the most common cause of this disorder. It was formerly very common in painters. It may rarely occur through ingestion. The condition appears rare and little can be added to the description given above from the *Statistical Guide*.

Psychoses Due to Gas

These psychoses are described by the *Statistical Guide* (002-359) as follows:

Under this heading should be placed the cases that develop mental disturbances from exposure to poisonous gases, particularly carbon monoxide in illuminating gas, and automobile exhaust. The preliminary period of unconsciousness may be followed by a more or less protracted delirium, after which the patient may be left with increased fatigability and difficulty in concentration. It should be recalled that persons who have suffered from carbon monoxide poisoning may appear to clear up entirely from the initial disturbance and have a free interval lasting weeks, to be followed by the appearance of symptoms from which they may not recover.⁹

ENDOGENOUS TOXINS

Endocrine Disorders

There is no specific relationship between endocrine disorders and mental disturbances. However, disturbances in the psychic field are not uncommon. The best known of the emotional disturbances associated with endocrine disease are the *delirium of thyrotoxicosis* and the *apathy of myxedema*.

1. *Disturbances of the Pituitary*

In the gigantism produced by hyperpituitarism, there are problems produced by the individual's abnormal size. He is conspicuous and unable to feel at ease in the company of his friends. This is likely to render him sensitive, shy, and introspective. He may have a tendency to withdraw himself gradually from society and to show schizoid tendencies. *Acromegaly* is frequently associated with irritability, moroseness, and depression. The acromegalic individual frequently seems out of touch with his environment and displays decreasing ability to concentrate. He may be sluggish in his thinking, emotionally unstable, and sometimes manifest unprovoked anger and homicidal tendencies. He is very often forgetful, suspicious, moody, and manifests unsystematized delusions of persecution. A psychosis may develop.

Hypopituitary dwarfism is associated with normal mentality which is also found in the true dwarf, whose intelligence is likely to be normal or above normal. Frohlich's syndrome (*dystrophia adiposogenitalis*) is likely to be associated with emotional instability and mental

retardation. Men so affected are usually impotent and sexual desire is retarded.

Simmond's disease is usually associated with early cessation of the menses when it occurs in women, muscular weakness, total or partial loss of memory, precocious senility, and numerous other physical manifestations. Its greatest importance, psychiatrically, is that it must be distinguished carefully from cases of anorexia nervosa.

2. *Disturbances of the Thyroid*

There is no special neurotic or psychotic syndrome necessarily attached to thyroid disturbances, but oversecretion of thyroxin by the gland is likely to produce fairly constant personality changes. Under its influence, the individual becomes more alert, high strung, ill at ease, anxious, overactive, and emotionally unstable. The patient is easily irritated or angered. He is startled by the slightest noise, unable to relax, suffers from insomnia, becomes easily exhausted, and is likely to lose weight. His appetite is variable, but is likely to be excessive. When the condition is extreme, the picture is likely to be that of the manic phase of the manic-depressive psychosis. His agitation may increase to a state of delirium with clouding of consciousness, unsystematized delusions, and transient hallucinations. This condition must be carefully distinguished from an anxiety state.

Cretinism, which results from hypothyroidism in children, usually appears early in life, rarely occurring after the seventh year. Physically, the cretin's growth is markedly retarded and his appearance characteristic. There is likely to be a marked delay or even inability to speak, and when speech is present, it is likely to be indistinct and meaningless. In untreated cases, the mentality of the cretin remains at the idiot or imbecile level. *Myxedema or hypothyroidism of adults* presents a picture almost the exact opposite of hyperthyroidism. All functions are markedly retarded. Inertia, exhaustion, apathy, and lack of initiative are outstanding traits. The individual, in advanced cases, thinks slowly and ineffectively. As the condition progresses, the intellectual deterioration becomes more marked, together with a notable lack of imagination. The general picture is that of an advanced schizoid state. While psychoses are rare in this condition, a syndrome resembling the depressed phase of the manic-depressive psychosis or of paranoid schizophrenia may occur. These states may be characterized by a great variety of illusions, hallucinations, confusion, and delirium.

3. *Disturbances of the Adrenals*

Addison's disease, which results from hypofunction of the cortex

of the adrenal gland, may very easily, in its early stages, be confused with neurasthenia. Its chief symptom is a gradual decrease in the physical strength which eventually leads to exhaustion. A great variety of somatic symptoms may be shown, and, as the condition advances, many psychic manifestations of a marked degree are likely to be found, such as confusion, disorientation, emotional instability, or even a true psychosis. Hyperfunction of the adrenals is quite likely to produce very marked physical disturbances, particularly in the sexual field, which are much more characteristic than any psychic changes that may occur.

Psychoses With Acute Infections or Resulting From Somatic Disorders

1. Psychoses Due to Diabetes

Although a great variety of mental disturbances are seen in diabetic individuals, it seems unlikely that the diabetes is the causative factor. It may, however, be the occasion of the disorder as a result of the strain created by the disease in an emotionally unstable, or prepsychotic, individual. Frequently seen in association with diabetes are depressions of either the manic-depressive type or of involutional melancholia. Phobias and hypochondriasis are also frequently present. There is no psychosis characteristic of the diabetic state except the delirium which may be found associated with overdoses of insulin or diabetic acidosis.

2. Psychoses Due to Uremia

Uremia is the end result of renal insufficiency and is characterized by gradual accumulation of the products of metabolism in the blood stream. As the condition progresses, mental symptoms almost invariably occur. Early manifestations may be anxiety, irritability, or a marked feeling of malaise. In association with these early mental manifestations, the patient is likely to become restless and confused. A delirium is likely to occur with clouding of consciousness, hallucinations, and delusions. As the condition progresses, and the patient becomes weaker, inattention, apathy, and inertia precede death. Convulsions frequently occur.

3. Psychoses Due to Vitamin Deficiencies

Vitamin deficiencies are seldom the cause of mental disturbances. The one exception to this occurs in pellagra, which is due primarily to an insufficient intake, absorption, or utilization of the pellagra-preventive (P-P) vitamin. Niacin (nicotinic acid) appears either to

be this vitamin or closely related to it. Pellagra is known to most students as the disease of the five "D's": (a) diarrhea, (b) dermatitis, (c) delirium, (d) dementia, and (e) death. In mild cases, symptoms of mental depression are common.

There are many subclinical cases of Vitamin B deficiency. A large number of recent articles in the literature seem to indicate that many cases of "neurasthenia" and acute psychoses may be evidences of Vitamin B deficiency.

4. *Puerperal Psychoses*

Much of the older literature gives the impression that at one time it was believed that there were psychoses associated with childbearing, very much as the more recent literature seems to connect a psychosis with menopausal changes. Neither concept has any psychiatric foundation. It is true that married life imposes many burdens and requires many adjustments. For those who have a previous psychopathic constitution, or those who are full of self-pity, who are in constant need of sympathy, or who are dominated by sentiment and emotion, there may be great difficulty in solving the problems connected with married life. These individuals may be seeking unconsciously for some escape from painful reality. They may find this incident in childbearing or lactation. Considered in this way, the puerperal psychosis serves as an escape mechanism, as the lesser of two evils, an admission of the individual's inability to adjust herself to married life and its conflicts. Such individuals have long conditioned themselves by the development of wrong habits of thinking, so that not only pregnancy, but any equivalent stress, might precipitate the psychosis. Such women are basically unstable, and have failed to develop an understanding of the philosophy underlying social and domestic society.

For a large number of women the period of pregnancy is one relatively free from mental unrest. For those women who were previously unstable or who find themselves with an unwanted pregnancy, any variety of psychosomatic symptoms may occur. Severe and protracted nausea of pregnancy is a frequent indication of the patient's desire to be freed of this unwanted responsibility. As the pregnancy continues and manifests itself in a loss of physical attractiveness, the patient is frequently depressed and wishes to remain alone, refusing to appear in public, and may even develop delusions of persecution. An aversion for the husband and sexual relations is not uncommon. Fear of the dangers of her impending parturition may give rise to severe anxiety.

The term "puerperal psychosis" usually refers to the psychic disturbances which occur between the first and eighth week after delivery. Most such reactions occur within the first ten days. The type of reaction which occurs most frequently is some variety of the manic-depressive psychosis or schizophrenia. In a few cases a toxic confusional state develops. The manic phase is more common and is of short duration. By the end of the second or third week there is usually a subsidence of symptoms, and it is not unusual at this time for symptoms of depression to appear. In those cases in which the puerperal psychosis takes the form of a schizophrenic reaction, it is usually characterized by apathy and indifference as to whether the patient lives or dies. She is oblivious to her environment and without interest in her child. There is a constant danger of suicide or infanticide. In many cases there is a tendency for the psychosis to recur with each pregnancy.

5. *Psychoses Associated With Infection and Exhaustion*

Psychoses resulting from infection and exhaustion emphasize the necessity of maintaining a psychosomatic viewpoint. They make clear the necessity of co-operation between the psyche and the soma. The physical organism, when exhausted by disease, cannot co-operate with the mind as an effective instrument in the process of thinking, willing, and judging. It lacks the vitality necessary for effective co-operation. Whether exhaustion occurs following excessive exertion, severe hemorrhage, prolonged malnutrition, or by wasting disease, the result is the same and the mind lacks necessary conditions for effective functioning. It responds sluggishly, and there may be, accordingly, clouding of consciousness, disorientation, or delirium.

Psychoses associated with exhaustion are conditioned by the psychotic personality of the individual and are unlikely to occur except in those in whom the soil has been previously prepared. In those psychoses resulting from infection, delirium is the outstanding manifestation. The emotional stability of the individual has much to do with the onset of delirium. In some it will appear at relatively low temperatures. Others, with greater mental stability, will show no evidence of delirium at a temperature of 105 degrees or even higher. As the temperature rises, the patient usually becomes more irritable, restless, and agitated, may be mildly confused and show some clouding of consciousness. He grasps ideas slowly and forgets quickly. The fully developed delirium consists of clouding of consciousness, disorientation, confusion, restlessness, bewilderment, hallucinations which

may be extremely vivid, and almost invariably amnesia for the events of the delirium. In most cases, the patient may be talkative, noisy, and difficult to restrain. In other instances, he is quiet, comatose, and muttering. Although the ideational content of the delirium is frequently concerned with familiar items of the patient's daily routine, it may be largely influenced by psychogenic problems with which he is concerned. These may appear in various guises, as they might in a dream, so that the content of the delirium may appear fantastic.

TREATMENT

The treatment of the toxic psychoses is basically that of the underlying condition, and reference should be made to a suitable medical or surgical text. There is no specific psychiatric treatment other than that mentioned in Chapter XVIII.

SUMMARY

The toxic psychoses result from the patient's psychic reaction to the introduction of a noxious substance into his system. Two sets of symptoms arise as a result of this toxicity: (1) Symptoms which result from the effect of the substance on the physical organism. These are present in some degree in every patient and their severity depends on the degree of toxicity. (2) Symptoms which result from the patient's psychic reaction to his disordered state. These depend upon the patient's previous personality and his present psychic needs. These differ naturally from one patient to another.

The most important of these disorders are due to alcohol. The treatment of toxic psychoses is dependent upon their cause.

FOOTNOTES

1. L. Goodman and A. Gilman, *The Pharmacological Basis of Therapeutics* (New York: The Macmillan Co., 1941), p. 109.
2. S. E. Jelliffe and W. A. White, *Diseases of the Nervous System* (Philadelphia: Lea and Febiger, 1935), p. 1064.
3. We obviously agree with Ford that "alcoholism is not the same thing as excessive drinking; not even the same thing as excessive drinking over a long period of time." To us it seems there is an element of both obsession and compulsion in alcoholism (John Ford, pp. 44-45).
4. Edward Strecker, *Fundamentals of Psychiatry* (Philadelphia: J. B. Lippincott Co., 1943), p. 85.
5. *Statistical Guide* (State of New York, Dept. of Mental Hygiene), compiled by H. M. Pollock, 12 ed. (Utica, N. Y.: State Hospital Press, 1943).
6. *Ibid.* (002-370).
7. *Ibid.* (002-345), p. 21.
8. *Ibid.* (002-310), p. 70.
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SOMATOPSYCHIC DISORDERS

In previous chapters we have discussed the nature of purely psychogenic disorders, i.e., disturbances in which the underlying brain structure is sound and does not contribute to the symptomatology. The group of disturbances now to be discussed are characterized by definite changes in the substance of the brain or other nervous structures. As pointed out elsewhere (chapter on Causality), the brain is a necessary condition for the functioning of the psyche or soul. These structures are complementary: one needs the other, and both must be present to make the complete man. Any serious damage to the brain structure is quite likely to interfere with the functioning of the mind which requires the more or less intact brain for its complete functioning.

Two groups of clinical manifestations of diseases should be kept in mind:

a) Symptoms. These are subjective manifestations of disease, experienced as such by the patient, and are not directly apparent to the observer.

b) Signs. These are objective manifestations of disease, observable by the examiner and usually due to organic pathology.

It is important to distinguish, therefore, between those disturbances in the individual which are based on psychogenic factors (disorder of thinking, judging, reasoning, and willing) and are usually experienced by the patient as symptoms, and those based on organic disease of the nervous tissues which are apparent to the examiner as signs. In all of the conditions which we are about to describe, there are certain characteristic physical signs which vary but slightly from one individual to another and which are due to characteristic organic changes in the tissues. These are primarily the concern of the neurologist. For most of these disorders, there is, however, no typical mental picture, although some such disturbance is usually, though not invariably, present. It is this psychic disorder, which is apparent to the patient as a symptom, which is psychogenic and is dependent in large part on the prepsychotic personality. It is not due to any organic change

but is due to the patient's psychic reaction to his disease or its consequences. As an example of this, it might be pointed out that in paresis the patient usually develops a tremor, speech disturbances, pupillary changes, and spinal-fluid abnormalities which are due to the organic changes taking place in his nervous system. These signs are rather constantly present and vary little from one individual to another. On the other hand the mental manifestations vary greatly from one patient to another, and it is these symptoms which are psychogenic and represent the patient's reactions to his disease.

Somatopsychic disorders may be defined as those whose onset and development require as a necessary prerequisite the presence of cerebral or spinal degeneration, organic disease, trauma, or some other type of physical disturbance in which the development of mental manifestations is the result of the patient's psychic response to the presence of the disease. It differs from a psychosomatic disorder in that in this case the disease contributes to the development of the psychic disorder rather than the psychic disorder producing the somatic manifestations. This type of psychosis is frequently referred to as an "organic psychosis." Such a designation is, strictly speaking, incorrect because all psychoses, no matter what be the circumstances under which they appear, are mental disorders.

The following topics will be discussed under the heading of "Somatopsychic Disorders":

VARIETIES OF SOMATOPSYCHIC DISORDERS

1. Neurosyphilis
 - a) Interstitial
 - 1) Meningitic type
 - 2) Meningovascular type (cerebral syphilis)
 - 3) Gummatous type
 - b) Parenchymatous
 - 1) General paresis
 - 2) Juvenile paresis
 - 3) Tabes dorsalis and taboparesis
2. Cerebral arteriosclerosis
3. Senile psychoses
4. Presenile psychoses
 - a) Pick's disease
 - b) Alzheimer's disorder
 - c) Presbyophrenia

5. Psychoses with chorea
 - a)* Huntington's chorea
 - b)* Sydenham's chorea (St. Vitus' Dance, chorea minor)
 - c)* Chorea Insaniens
6. Posttraumatic disorders
 - a)* Posttraumatic delirium
 - b)* Posttraumatic personality disorder
 - c)* Posttraumatic mental deterioration
7. Posttraumatic psychoneuroses
8. Epidemic encephalitis (sleeping sickness)
9. Paralysis agitans (shaking palsy, Parkinsonism)

CLINICAL MANIFESTATIONS COMMON TO MOST SOMATOPSYCHIC DISORDERS OF THE BRAIN

1. Exaggeration of previous personality traits.
2. If previously moral, such feelings may deteriorate and behavior may be in marked contrast to previous habits.
3. Impairment of memory. The memory impairment may be associated with (*a*) confabulation, (*b*) disorientation, (*c*) confusion, (*d*) defective judgment, and (*e*) impairment of retention and comprehension.
4. Decreased ability to think abstractly.
5. Fluctuation in attention, difficulty in grasp.
6. Decreased ability to perform skilled muscular acts—for example, speech defects.
7. Habit deterioration.
8. Emotional instability. There may be periods of confusion and bewilderment.

NEUROSYPHILIS

Syphilis is the most frequent disease of the central nervous system. According to Brain,¹ syphilis is the cause of one in every seven cases of organic nervous disease. In spite of this marked prevalence of the disorder, the relationship of syphilis to diseases of the central nervous system has only been well understood during the past century. One reason for this is undoubtedly the fact that the cerebral manifestations of syphilis occur only after a very long latent period. Until modern methods of neuropathological research were devised, there was little to link the early and the late manifestations of the disease. Another reason which undoubtedly delayed its recognition was the ability of syphilis,

"the great imitator," to mimic almost any other neurological disorder. Thus, differentiation of neurosyphilis from other diseases of the nervous system requires a very broad understanding of the field of neurology.

For those who are not familiar with the clinical picture of syphilis, it should be pointed out that syphilis occurs in three stages. These are usually referred to as the primary, secondary, and tertiary stages.

The primary stage manifests itself, usually, as a single lesion, which is called a chancre, which usually appears at the site of the infection. The incubation period of the first stage of syphilis may vary from three to six weeks or even longer.

The secondary stage of syphilis usually develops from six to twelve weeks after the appearance of the initial lesion. It manifests itself, usually, as a feeling of malaise with slight fever, sore throat, and skin eruption, which varies in its characteristics very widely, and is very difficult to diagnose except in the presence of other luetic manifestations.

The tertiary stage of syphilis may not be manifest, clinically, for as long as fifteen to twenty-five years after the initial infection. It is characterized by the appearance of gummata or granulomatous lesions which may involve any tissue in the body. It is usually this tertiary stage of syphilis which involves the central nervous system.

In the older terminology, a fourth stage of syphilis was frequently referred to; however, this term has been generally discarded and the neurological manifestations are, at the present time, regarded as evidence of tertiary syphilis.

General Background of the Neurosyphilitic Psychoses

In 1610, Guarinoni referred to epilepsies which were caused by syphilis. Paralysis was associated with mental disorders by Thomas Willis in 1672, and Sanche described a manic in 1777, the cause of which he attributed to syphilis. Jelliffe found references in literature to a specific leptomeningitis in 1766, and paraplegia in 1771. Haslam, a pharmacist, gave a comparatively accurate description of general paresis in 1798. A Frenchman, A. L. Bayle, is given credit for differentiating the disease in 1822. However, this psychosis was not recognized as an entity until the comprehensive work of Calmeil established it in 1846. The cause of the disease was a subject of dispute for many years. Schaudin isolated the spirochaeta pallidum in 1905 and settled the controversy as to the cause of syphilis. The work of Wassermann, Neisser, and Bruck in 1906 on syphilitic fluids proved the relations

between general paresis and syphilis. Moore and Noguchi showed the treponema in the cortex of paretics in 1913.

Neurosyphilis occurs in two forms: (1) interstitial syphilis, and (2) parenchymatous syphilis.

Interstitial Syphilis

Interstitial syphilis is described in the *Statistical Guide* under 003-147 as follows:

Under this heading are to be classified cases in which the history, signs and symptoms, including serology, point to a primary and predominating involvement of the meninges and blood vessels rather than of the parenchyma of the nervous system. Indicating cerebral syphilis rather than paresis are: comparatively early onset after infection, sudden onset with confusion or delirium, focal signs, particularly cranial nerve palsies, apoplectic seizures, very high spinal fluid cell count, positive blood Wassermann and negative spinal fluid Wasserman and the luetic type of gold curve, often prompt response to systemic antisyphilitic treatment. Under this heading are also to be classified those cases of chronic syphilitic meningitis which may show mild or severe deterioration in emotional and intellectual reactions, but which usually, nevertheless, show a clinical picture distinguishable from the parietic.²

Interstitial syphilis is more of a neurological than a psychiatric disease. Interstitial syphilis is primarily degenerative of the meninges and supporting tissues and secondarily inflammatory of the parenchyma. Interstitial syphilis may be, therefore, looked upon as the attack by the spirochete on the meninges and supporting tissues. Since interstitial syphilis is not infrequently associated with mental disturbances, it is well to bear in mind the possibility of this condition.

Interstitial syphilis manifests itself in three varieties: (1) meningitic type, (2) meningovascular type (cerebral syphilis), (3) gummatous type.

1. Meningitic Type

Syphilitic meningitis has as one of its outstanding characteristics the fact that it occurs at a much earlier period in the course of the disease than any other form of neurosyphilis. It not infrequently occurs during the secondary stage of the disease and seldom reveals itself later than five years after its onset. Usually the onset of syphilitic meningitis is slow and the fully developed picture of the disease may not appear for a week or ten days. In some instances, however, an acute form

occurs with a sudden onset which resembles that of the acute pyogenic types of meningitis.

Clinical manifestations. Clinically, the condition resembles any other type of meningitis.

a) The usual signs of meningitis are present, including stiffness of the neck, a positive Kernig reflex, and frequently a positive Brudzinski's sign.

b) Cranial nerve involvement, especially involvement of the second and third cranial nerves, is more frequently present than in any other type of meningitis.

c) The spinal-fluid changes, while not characteristic, may be diagnostic. There is usually an increased cell count which may rise to one thousand cells or more, mostly lymphocytes; the protein is usually increased, so also the pressure.

d) The serology of the spinal fluid is frequently positive (85 per cent), and the colloidal gold curve shows changes (95 per cent) usually in the first or second zones. The blood Wassermann is positive in about 60 per cent of the cases. (See Charts 1 and 2.)

Mental manifestations. The psychic changes are variable depending to a large extent on the acuteness of the infection.

a) The changes found are those characteristic of a toxic delirium.

b) In the more severe forms the patient may develop a typhoidal state, characterized by a muttering delirium.

c) In other cases, although there may be marked clouding of consciousness, the patient can usually be aroused to answer questions.

d) A severe headache is usually present which is said to be worse at night.

e) As a rule the patient retains his critical faculties and has good insight into his condition which in many instances may give rise to a severe anxiety.

f) In certain predisposed individuals a psychosis may result.

2. Meningovascular Type

In this condition the pathological changes arise from a luetic involvement of the cerebral blood vessels which results in their gradual occlusion. Because of this, there is a diminishing blood supply to the brain tissues with the development of areas of softening. It is difficult, from the clinical standpoint, to distinguish the cerebral changes of vascular syphilis from those of arteriosclerosis, except for the fact that it usually occurs in relatively young or middle-aged individuals in whom other evidences of syphilis may be found.

CHART 1. Spinal-Fluid Changes

	Normal	Syphilitic Meningitis	Tabes Dorsalis	Paresis	Meningo- vascular Syphilis	Encephalitis
<i>Appearance</i>	Clear, transparent, colorless	No change	No change	No change	No change	No change
<i>Pressure</i>	100-200 mm of water, 0.8 mm of Hg	May be slight increase	Increase	Increase	Normal or slight increase	Normal or slight increase
<i>Coagula</i>	None	None	None	Occasionally present	None	None
<i>Color</i>	Water	No change	No change	No change	No change	No change
<i>Cell Count</i>	0-8 cells per cmm-lympho- cytes	Slight to moderate increase	Slight to moderate increase	Slight to moderate increase	Slight to moderate increase	Slight to moderate increase
<i>Protein</i>	15-40 mg per 100 cc	Increase ++ to +++	Increase +	Increase ++ to +++	Increase +	Increase +
<i>Glucose</i>	50-75 mg per 100 cc	No change	No change	No change	Slight increase	Slight decrease
<i>Chloride</i>	700-750 mg per 100 cc	No change	No change	No change	No change	No change
<i>Colloidal Gold</i>	0000000000	0001224530 Zone 3	1123321000 Zone 2	5555432200 Zone 1	0123321000 Zone 2	5544320000 Zone 1
<i>Wassermann</i>	Negative	Usually positive	Usually positive	Always positive	Negative	Usually positive

CHART 2. Colloidal Gold

COLOR CHANGE	Tube No.	1	2	3	4	5	6	7	8	9	10
	5	×	×	×	×				-		
	4					×		-			
	3				0	0	×			-	
	2			0		-	-	×	×		
	1	0	0		-		0				
	0	-	-	-				0	0	0	-
										×	×

× = Paretic Curve (Zone 1) 5555432200

0 = Tabetic Curve (Zone 2) 1123310000

- = Meningitic Curve (Zone 3)
0001224530

0 = Brilliant red-orange (no change)

1 = Red-blue

2 = Lilac or purple

3 = Blue

4 = Pale blue

5 = Complete decolorization

Reference: CLINICAL DIAGNOSIS,
John A. Kolmer,
D. Appleton-Century Co., 1943

Clinical manifestations. Under ordinary circumstances, the condition is rather slow in developing and many prodromal manifestations may occur. The most common of these are *headaches*, *convulsions*, and a *gradual mental and emotional deterioration*. In some instances there may be localized involvement of the vessels, in which case focal symptoms may point to the site of greatest involvement. The gradually developing ischemia eventually leads to a cerebral thrombosis, which in turn produces an area of infarction. The clinical picture will naturally depend upon the area involved. The usual sequence of events is the gradual development of hemiplegia with spasticity of the side involved, increased reflexes and the appearance of the Babinski sign. An Argyll-Robertson pupil may be present. An *apoplectic type* occurs in which there is a sudden appearance of the hemiplegia associated with coma. In most instances, this is rapidly fatal. *Spinal-fluid findings* in meningovascular syphilis are inconstant. There is usually, however,

an *increased cell count and a moderate increase in protein*. The serology and colloidal gold curve are not characteristic. (See Charts 1 and 2.)

Mental manifestations. There are no characteristic mental changes in this condition. As a rule, the individual retains good insight and has good practical judgment. He ordinarily understands the significance of the condition and its implications, and as a result is frequently anxious and depressed. Memory difficulties are common, particularly for recent events, although the patient may also display considerable uncertainty about remote events. As the condition develops, he may display a progressive intellectual and emotional deterioration and may become dull, inert, or even comatose. His orientation for time, place, and person may become defective. There is a tendency for the symptoms to vary in their intensity from time to time and intermittent lucid intervals are characteristic. During these periods he may show marked emotional instability, characterized by excitement, irritability, depression, restlessness, or he may swing in the opposite direction and become euphoric and overactive. *The entire psychiatric picture takes perspective and color from the prepsychotic personality of the individual.* His previous personality is the dynamic factor in the development of his symptoms.

It would be a grave mistake to attempt to consider separately the mental and clinical pictures. Both are essential phases of the disorder.

3. *Gummatous Type*

Gummata are tertiary luetic manifestations and may vary in size from a microscopic lesion to the size of a walnut. These usually start from the dura mater or arachnoid and extend into the brain tissue. They may occur in any portion of the brain, but are most frequently found in the base; as a consequence, involvement of the cranial nerves is frequent.

The clinical manifestations produced by gumma resemble rather closely those of a brain tumor which, as a matter of fact, it resembles, although it is infectious in origin. As in a tumor, it produces its changes by infiltration or pressure and consequently produces focal manifestations.

CASE 46: *Psychosis With Syphilis of the Central Nervous System, Meningovascular Type*

A white male, age 47, was brought to the hospital apparently in good physical health, except for blindness. He gave a history of

syphilis, had recently suffered a "stroke," followed by hallucinations, confusion, dullness, and some grandiose ideas. The patient's family history was apparently normal. The date of primary syphilitic infection was uncertain, between ten and twelve years previously. He learned of it years ago and received treatment from his doctor. He had become blind a year and a half ago.

His present illness began a month before admission, when he suffered an apoplectiform seizure while at work. He became expansive, thought he had city lots to sell, that he was going into the Coast Guard, even though blind. Following the seizure, his speech became thick, he became restless and hallucinated. Admittance examination showed him to be quiet and co-operative but delusional, stupid, untidy, emotionally depressed, mentally slow, and confused. He denied having knowledge of lots in the city, of trying to sell them, or of considering Coast Guard work. He was disoriented for time, place, and person. His recent and remote memory was impaired. He thought there were 54 states in the Union. He understood he had syphilis, but stated his mind was clear and there was no reason for his presence in the hospital. He exhibited moderately exaggerated tendon reflexes. Romberg and Babinski tests were not present; there was no apparent ataxia. Spinal-fluid examination showed: cells 29, globulin 2 plus, Wassermann 4 plus in 0.5 cc., colloidal gold curve 5443332100. The patient was given a course of malaria and his vision temporarily improved. There was no other change in his mental or physical condition. After several years his condition remained stationary.

Prognosis. In the meningitic type, even in those cases which are recognized early and treated promptly, the mortality may be as high as 20 per cent.

In cases of meningovascular syphilis, the outlook is good in those cases which are diagnosed and treated early. It is difficult to give a very definite prognostic opinion in cases of meningovascular syphilis, because in many instances of even fully developed hemiplegia, there is a peculiar tendency for the symptoms to disappear spontaneously, even in the absence of any form of treatment.

Gummatous syphilis responds poorly to therapy.

Parenchymatous Neurosyphilis (General Paresis)

The *Statistical Guide*, under (002-147) meningoencephalitic type (general paresis), gives the following:

. . . Under this heading are to be classified cases showing rapidly or slowly progressive organic intellectual and emotional defects with

physical signs and symptoms of parenchymatous syphilis of the nervous system and completely positive serology, including the paretic gold curve. Cases showing symptoms suggestive of manic-depressive, dementia praecox or of other constitutional psychotic reactions, but showing also physical signs and symptoms of syphilis of the nervous system and positive serology, particularly the paretic gold curve, are to be listed here rather than under other headings. It is to be remembered that with the modern methods of treatment a number of paretics may be found with negative serology. Here the history, particularly that of the length and nature of treatment, must be taken into consideration in making the final classification.³

Definition of General Paresis

General paresis is a somatopsychic psychosis caused by the individual's inadequate psychic reaction to the invasion of the cerebral cortex by the spirochete of syphilis or its toxin and is characterized by serious personality disintegration as well as by rather constant physical signs and serological findings.

It may also be described as *a late chronic meningoencephalitis found in connection with a severe somatopsychic disorder characterized by progressive mental deterioration and personality disintegration, various neurological dysfunctions, and usually positive blood and spinal fluid serological reactions for syphilis.*

Explanation of the Definition

a) General paresis is a psychosis. There is, therefore, serious personality disintegration usually evidenced by delusions and hallucinations.

b) General paresis is somatopsychic. It is universally admitted that the presence of the spirochete of syphilis or its toxins and the resulting pathological tissue is a necessary condition or prerequisite for the development of this psychosis. The parenchyma is invariably attacked by the spirochete of syphilis prior to the onset of general paresis. "No syphilis, no general paresis" is now a universally accepted axiom.

c) Caused by the individual's inadequate psychic reaction to the invasion of the cerebral cortex, by the spirochete of syphilis or by its toxins. The mental symptoms of general paresis do not result from tissue degeneration but from the inadequate psychic response made by the individual.

Etiology

Of those who contract syphilis, about 25 per cent develop neurosyphilis. Of these, somewhat less than 5 per cent develop general

paresis. The condition usually appears ten to twenty years after the initial lesion, although in some instances it may appear earlier. In cases appearing before the twenty-fifth year, the possibility of juvenile paresis, which is the result of congenital syphilis, should be considered. It is more frequent in men than in women. Although the relationship of syphilis to general paresis was for a long period not recognized, it is now universally conceded that syphilis is the cause of general paresis. There has been considerable thought given to the question as to why so few syphilitics develop general paresis. Some have thought that a definite neurotropic strain of the organism was responsible. According to this view, one type of organism had an affinity for somatic tissues, another for the spinal cord, a third for the meninges and the blood vessels, and another more virulent strain for the parenchymatous tissues. This matter is still unsettled. It is interesting to note that paresis is practically unknown among aborigines, although syphilis is common, and there is a tendency for more cases to occur among educated, intelligent people than among laborers and the uneducated. Another opinion which has been expressed but not confirmed is that paresis may be produced by a toxin liberated by the spirochete rather than by the spirochete itself.

In considering the question of etiology, one cannot overlook the objective fact that over 95 per cent of those who have syphilis never develop general paresis. Moreover, it is quite likely that the parenchyma is in many instances invaded by the spirochetes as shown by autopsy material without the production of general paresis. Taking these facts into consideration, it seems likely that something more than the spirochete and the degeneration it produces is necessary to explain the distortion of the personality manifested by paretics.

As has been previously emphasized, the prepsychotic personality of the individual is an important factor in the production of the paretic picture. Well-balanced personalities yield less readily to the invasion of the spirochete. Paresis is, therefore, correctly considered a somatopsychic disturbance.

Clinical Manifestations of General Paresis⁴

a) *Prodromal symptoms.* Although there are no typical prodromal manifestations of general paresis, there are certain symptoms which frequently precede it. Most common of these are migrainous types of headaches, attacks of vertigo, neurasthenic symptoms, transient weakness of an extremity, transitory paralysis of extraocular muscles with

diplopia, and fleeting nocturnal enuresis; a rare condition known as erythropsia may occur. This is a condition in which the patient's entire field of vision is filled with darting red spots.

b) *Onset*. The onset of the condition may be insidious or abrupt. In about 50 per cent of the cases its onset is initiated with a convulsion which is epileptiform in type. Focal seizures and petit mal attacks are not unusual.

c) *Pupillary changes*. The Argyll-Robertson pupil is common, and some type of pupillary abnormality usually develops. Optic atrophy is not uncommon.

d) *Speech disturbance*. Since 1814, when Esquirol first described this symptom, its significance has been frequently stressed. The characteristic paretic's slow, slurred manner of speaking may be best elicited by such test phrases as "Methodist-Episcopal," "hard-riding artillery brigade," and "Constitution of the United States." Some of the speech difficulty may arise from tremors which characteristically appear in the tongue and other parts of the body. Although considerable stress was laid upon slurred speech in the older writings, it is not considered as important a manifestation at the present time as it formerly was.

e) *Change in handwriting*. There is usually marked alteration in the patient's style of handwriting which is chiefly characterized by the fact that the writing is often smaller, although occasionally larger, than is customary for the patient. There is inequality in the size and shape of the letters, and skipping of words or doubling of syllables may be noted. These changes are, on the whole, progressive, and the writing becomes progressively more deteriorated and nonsensical.

f) *Motor phenomena*. In addition to the tremor noted above, a generalized motor weakness is likely to occur. In-co-ordination eventually develops which renders the patient ataxic and produces defective handwriting. Reflex changes are variable, but as a rule tendon reflexes are increased.

g) *Spinal-fluid changes*. The spinal-fluid findings are characteristic. In an untreated case the diagnosis of paresis should not be made unless the serology is strongly positive. In treated cases there will naturally be variations in the serology. Spinal-fluid pressure is usually somewhat increased. The cell count seldom rises over 100 with most of the cells being lymphocytes. The protein is moderately increased. Lange's colloidal gold curve is almost always elevated in the first zone, a typical curve being 5554433111 (see Chart 2).

Mental Manifestations

The psychic manifestations in paresis usually precede the physical manifestations. The first change noted is an impairment of intellectual efficiency. This may be so slight as to be not recognizable, except by those who know the patient well. For this reason, members of the family and business associates may notice changes in the patient before they are apparent to those less familiar with him. The classical onset of paresis with grandiose delusions and euphoria is comparatively unusual. *More frequently the onset is characterized by neurasthenic symptoms with complaints of loss of energy, somnolence, and a hypochondriacal preoccupation over the symptoms.* Because of the predominant involvement of the frontal lobes, the more recently acquired skills are usually the first to disappear. Along with this disappearance, there arise defects in the sphere of moral and ethical sense, and of judgment. Memory is always impaired, and as the condition progresses there is a very marked tendency for the patient to become *careless in matters of dress and extravagant in his expressions and expenditures.* Insight is severely impaired, but some partial realization on the part of the patient as to what is happening to him may bring on periods of excitement or depression. Delusions and hallucinations invariably occur.

Various *types of paresis* have been described because of certain predominating symptoms. The *simple dementing type* is most common and is so called because of the presence of progressive mental and physical deterioration. The *maniacal type* is associated with sudden outbursts of violence and delirium. Emotional depression is characteristic of the *depressed type*, and paranoid delusions of the *paranoid type*. The *expansive grandiose type*, so frequently described by the older texts, is apparently not as common as was formerly thought.

The following case demonstrates a typical paranoid type of general paresis.

CASE 47: General Paresis — Paranoid Type

The patient was a white female, age 40. No family history was available. She had been raised in an orphanage until she was 11 years of age. Twice she had been placed with farmers, but each time had been returned to the orphanage, from which she ran away at the age of 14. She did various types of common labor to the age of 19. She became pregnant at 21, had an abortion at three months. Two

years later she had an illegitimate child. She had another abortion about two years after this. She married when 25, had a legitimate child from this union, and lived with her husband until three years ago, at which time she divorced him because of "mental cruelty." She admitted being unfaithful to her husband. For the past three years she had lived promiscuously. She was always excitable, highly emotional, and erratic, but also very kind and affectionate. She drank only moderately. During the past five years she underwent surgery for salpingitis, appendicitis, and two abortions. Her present illness began with a sudden onset about three weeks prior to admission to the hospital and was characterized by marked emotional instability, inadequate affect, bizarre delusions, and auditory hallucinations. Reflexes were active. The spinal-fluid findings were: cells 150, globulin 2 plus, Wassermann 4 plus, and colloidal gold curve 5555544332.

She was fairly co-operative at the time of admission. She stated that she had venereal disease of the brain and thought that she was going to die in her room. She laughed and cried alternately. She was acutely disturbed the first six weeks of hospitalization, and it was impossible to gain any information from her. She ate and slept well. Her emotional reaction was inappropriate, varying from elation to dejection. Psychomotor activity was very changeable. She talked in a rapid manner, was very distractible and hallucinated. At times she stated, "It is lots of fun," at other times, "Not so funny." She stated that she was abused, mistreated, going to die, and asked for poison. At the time of examination, the patient was oriented in all three spheres. Memory for remote events was fairly well retained, but indefinite for details. Her memory for recent events was poor. She was very confused regarding events leading up to her commitment. School and general knowledge were poorly retained. Insight was lacking and judgment was poor. Neurological examination showed that the pupils were equal, round, and reacted to light and accommodation. Superficial reflexes were present and equal except that the lower abdominals were absent. Deep reflexes were present and equal. Romberg was negative. No pathological reflexes were found.

The patient continued to show marked emotional instability, alternating from periods of crying to outbursts of wild laughter. Following completion of malaria therapy she showed some improvement to the extent that she was more co-operative and quieter. Further treatment effected no particular improvement and her condition was such that she was transferred to the disturbed ward, where she was extremely noisy, irrational in speech, hyperactive, and talkative. Shock therapy made her less noisy and she began to help with some of the

ward work. Emotionally she was unstable and talked in a silly manner, and it was evident that she hallucinated constantly.

Three years after admission she had adjusted fairly well to hospitalization, was neat and tidy in appearance, and co-operative with the personnel. She still retained her delusions and her conversation had a marked sexual trend. Her memory was intact for both remote and recent events. She stated that she was railroaded into this hospital by the Catholics and that she should be instantly released. She was not a trustworthy patient, as she hoarded everything she could find and picked up anything she could lay her hands on. She ate and slept well. She was able to work in the art room and was quite clever in sewing and embroidery. She was known as a "general nuisance" on the ward and lied without restraint concerning any situation in which she was the offender. She became very grandiose in manner and assumed a "high and mighty air" among other patients on the ward. She was extremely talkative but rational in conversation, and she expressed a wealth of grandiose, paranoid ideas. Her intellectual deterioration seemed to have been checked somewhat, due to the large amount of antisypilitic treatment she had undergone since entering the hospital.

Prognosis

The prognosis of untreated general paresis is not good, and death usually occurs in two to five years. Spontaneous remissions may occur. Treatment may induce prolonged remissions.

Terminal Dementia

The progression of the symptoms described above results in a terminal dementia. The patient's external senses scarcely respond. Memory, judgment, will, and speech fail. He becomes helpless and unable to take care of his personal needs.

CASE 48: General Paresis With Deterioration

A white male, age 43, had a normal early development, a high school education, the occupation of salesman, and a history of promiscuity. He had been married twice and divorced from each wife because of desertion. There was no history of serious illness or injury and no definite history of venereal disease. The onset of his present illness evidently occurred six months before admission and was characterized by euphoria, exaltation, a continuous stream of conversation, expansive ideas, thinking that he owned hospitals and hotels all over the entire world. He exaggerated any topic of conversation in a grandiose manner. He stated that he had been

hunting with the greatest men in the country, including Henry Ford, President Roosevelt, and John Pierpont Morgan.

On admittance, the blood Wassermann and spinal fluid were both found to be 4 plus, with a spinal-fluid cell count of 12. He was markedly confused, disoriented for place and time, and his general knowledge was poorly retained. He revealed marked slurring of speech, and his memory showed defects for recent events. Physical examination revealed an athletic type of white male. Left pupil reacted to light and was larger than the right one, which did not react to light. Neurological examination could not be performed because of lack of co-operation on the part of the patient. Laboratory findings also showed a four plus Kolmer in the blood, and spinal-fluid examination revealed a pressure of 30mm. of mercury, globulin 1 plus, cell count 11, colloidal gold curve 5544210000.

The patient was surly and resentful after admission. He sat with his eyes closed, saying he wanted to rest them. When asked about venereal infection, he denied it vehemently; he admitted that he had limitless wealth, but refused to go into details. He displayed many peculiar mannerisms, such as tapping on the chair continuously with his fingers, stamping his feet, mumbling to himself all the time, and disturbing all about him. He was given malaria treatment, but was very un-co-operative during the course of therapy and required restraint. He was extremely delusional, disturbed, and irritable following this therapy. Ophthalmoscopic examination revealed moderately advanced luetic optic atrophy. He was untidy in personal habits and was markedly delusional in a grandiose manner. He thought he was the President. In 1941, mental deterioration was increased, and he was one of the untidy, dilapidated patients on the ward. He was very abusive in language, surly in talk and manner, and resented being called by his correct name, demanding that he be recognized as the President or Chauncey Olcott. Slow, progressive mental deterioration continued to the point where his conversation was an unintelligible mumble, his personal habits filthy, and he was incontinent of both urine and feces. He continued to demand that he be addressed as Chauncey Olcott.

Juvenile Paresis

Neurosyphilis occurs in from 8 to 10 per cent of congenitally syphilitic children. It is usually of the interstitial type. Parenchymatous syphilis occurs in only 1 per cent. In those who eventually develop juvenile paresis, other evidences of syphilis are usually present, and as a rule the children are defective mentally from birth. The onset of the condition may be gradual, but is occasionally abrupt. The mental

symptoms on the whole differ little from those of the acquired form, except that the children are rarely hallucinated or maniacal. They are frequently surly or apathetic. The physical changes are also similar to those present in the acquired condition. Many combinations of focal meningovascular and spinal symptoms may occur in congenital neurosyphilis, and in 10 to 15 per cent of the cases tabes dorsalis will also be present. The course of the disease in untreated cases runs from five to ten years. It is not as rapidly progressive as in the adult types, but the prognosis is very bad.

CASE 49: *Juvenile Paresis*

White male, age 23, unmarried. This patient's family history was negative, except that his mother was emotionally unstable. Birth and early development were normal. He was a graduate of high school. He was normal up to the age of 20, when he was thoroughly shaken up in an automobile accident. He had been an honor student in high school because of his skill in architectural drawing. He neither drank nor smoked. Soon after the automobile accident he developed disconnected speech and became tremulous. He also developed childish behavior, was stubborn, ill-tempered, confused, cried out at night, and was incontinent. He exhibited severe degrees of mental and emotional disintegration. His emotional reactions had two predominant features, one being fear, the other response to friendly persuasion by fawning and fatuous grins. His whole reaction was reminiscent of a caged wild animal. He was completely disoriented. He appeared to have lost all faculties of reasoning, ability to calculate or to recall any learned knowledge. He was unable to read or write, and in every respect his intellectual faculties appeared to be totally disintegrated. He gave vent to bestial cries, all the while glancing about in a wild, startled manner. He ate ravenously in an animal-like fashion. He was resistive but not combative.

His mental and physical condition was that of a severe grade of mental and emotional disintegration. There was a very marked speech defect with positive neurological findings while laboratory findings were positive for central nervous system syphilis. The cell count was 240, globulin 2 plus, Wassermann 4 plus in all dilutions, and the colloidal gold curve was 5554433221.

A checkup on his mother's serology revealed syphilitic infection. The patient was started on antiluetic treatment within two weeks after admission. He was given a course of tryparsamide and thiobismol within the month following, but showed no favorable response to

this form of therapy. He continued to be noisy, unable to converse rationally, scream in an animal-like manner, to be incontinent, and to exhibit destructive tendencies. He was given metrazol treatment, even though the prognosis seemed to be hopeless, in an attempt to alleviate the acute mental symptoms. After the first treatment he was able to be up, without restraint, for the first time, and attendants reported that he appeared to talk more intelligibly than ever before.

However, he was returned to bed rest the following day because of the development of an ulcer on the right buttock. Improvement was only transitory, and he relapsed again into his former state, resistive to any form of treatment, noisy at all times, and extremely restless. When at bed rest on his stomach, he kept moving his head about, causing superficial abrasions on the skin of his face. Five months after admission the patient became comatose and could not be roused and had an elevation of temperature to 103 degrees. He died two days later.

Diagnosis

The diagnosis of general paresis in untreated cases is easily made if the spinal fluid is examined, because *all cases will show positive spinal-fluid findings*. All patients showing a change in personality should have a spinal-fluid examination. All patients giving a history of syphilis should receive a spinal tap at least every five years, particularly those who show symptoms of neurasthenia. The differentiation of paresis from interstitial forms of syphilis may at times be quite difficult, but if consideration is given to age, the presence of delusions, other psychic disturbances, and the spinal-fluid findings, this differentiation will usually be possible.

Tabes Dorsalis

Definition

Tabes dorsalis is a late syphilitic disease of the dorsal roots of the spinal nerves with an ascending degeneration of the posterior column of the spinal cord. It is characterized by disturbances in gait and coordination, and by diminished or absent deep reflexes, pupillary abnormalities, and severe "lightning" pains.

Etiology

Although there are other disorders with varying causes whose symptoms closely resemble those of tabes dorsalis, this disease is always syphilitic. It occurs most frequently between the ages of forty and fifty; in some few cases it has occurred earlier. It seldom appears before the

fifteenth year following infection, though in rare instances it has been noticed as early as the seventh year. One to two per cent of those patients having neurosyphilis develop tabes dorsalis.

Clinical Manifestations

These are extremely numerous and variable, some of them more characteristic than others. Most of them result from the disturbance in the posterior column of the spinal cord which interferes with or prevents the passage of nervous impulses from the periphery to the cerebral centers. Disturbances of sensation are common. Pain on deep pressure over the Achilles tendon and testes may be lost. Vibration sense is frequently lost early in the disease. Ataxia is usually a late manifestation and may be described by the patient as an inability to walk in the dark. This results from a loss of joint sense, a loss which results from the disease of the posterior column. The steppage gait so typical of the condition is brought about in the same manner. *Deep reflexes, especially the knee jerks, are either lost or greatly diminished.* A positive Romberg is usually present. Speech and writing ability are much better preserved than in general paresis. *Cranial nerve involvement is quite common.* The optic nerve degenerates with resultant blindness in 10 to 15 per cent of the cases, and strabismus, ptosis, and deafness are not unusual. The Argyll-Robertson pupil is more frequent in this condition than in any other. Bladder disturbances and loss of libido and potentia are common.

Pain is a characteristic early manifestation. It is usually referred to as a "lightning" pain. These pains, usually stabbing in character, occur most frequently in the extremities and, as a rule, do not radiate but remain localized in one spot and are of very short duration. Root pains, experienced by the patient as a painful sense of constriction around the chest or abdomen, are not uncommon. The spinal fluid is almost always positive in untreated cases. The cell count and protein are moderately increased and Lange's colloidal gold curve usually shows some changes in the first or second zones. (See Chart 1.)

Mental Manifestations

Since tabes does not affect the cerebrum, it would not be able to produce, as a result of its pathological changes, any mental manifestations. In fact, in a pure case of tabes dorsalis, there are, as a rule, no primary psychic changes. Since the tabetic retains insight, he may realize that he has syphilis of the central nervous system and is aware

of the possible consequences. This realization may be followed by depression, anxiety, or agitation.

Prognosis

The prognosis for cure is practically hopeless, and, in spite of treatment, the course of the disease is usually progressively downward, although there may be short periods of intermission in the progress of the disease.

Taboparesis

About 10 per cent of those who have *tabes dorsalis* eventually develop general paresis. Depending upon which disease predominates, the patient will then assume the physical or psychic syndrome characteristic of that condition.

CASE 50: *Taboparesis*

A 50-year-old white man was sent for examination with a history of a few months' duration of increasing confusion and forgetfulness, with complaints of dizziness, failure of vision, and pains in his legs. Examination showed marked emotional flattening, spotty memory defects, and marked diminution of powers of concentration. The physical examination showed absence of knee jerks, slurring speech, rather sluggish pupils, and a positive Romberg. The serology was indicative of tabetic change.

His early personal history was normal. He drank moderately, his marital life was happy, and there were no children. He was once afflicted with rheumatism and spent a great deal of money in the hope of a cure. Later he began to tire very easily at his work, became very quiet, less talkative, and seemed to withdraw into himself. About six months ago he became "nervous," irritable, and worried over his failure to produce his citizenship papers. The radio annoyed him, and he complained of severe pains in his legs. He perspired freely, but constantly complained of feeling cold, although the time of year was summer. He was advised that treatment in a mental hospital was indicated and volunteered to enter of his own volition. Within two weeks following admission he was inoculated with malaria. He ran a full course, which was terminated because of sharp decline of his hemoglobin and red cells. Physically and mentally he responded excellently to this therapy and appeared to be in a splendid condition. There were no psychotic symptoms, although his speech was somewhat slurred, gait was tabetic, knee and foot jerks were absent. He maintained his improvement after leaving the hospital and was discharged, much improved, a year later.

CEREBRAL ARTERIOSCLEROSIS

Cerebral arteriosclerosis is commonly referred to as hardening of the arteries and the arterioles of the brain. This usually is a part of a generalized sporadic process involving the blood vessels which begin to occur in most individuals after the age of forty. Although the process is usually generalized, it may predominantly involve either the brain, the kidneys, or the heart, and such involvement may lead to such typical clinical pictures as coronary heart disease or chronic nephritis. Where the process predominantly involves the cerebral blood vessels, certain symptoms may be produced. Not all individuals who have cerebral arteriosclerosis eventually develop a form of dementia. Such individuals may stop anywhere along the course.

Etiology

Very little is known of the cause of arteriosclerosis. Why it should pick on one organ more than another, as it frequently does, is also a subject of research.

Clinical Manifestations

Some feebleness of mind is normally characteristic of the aged. This condition is usually referred to as "senility" or "dotage." These changes due to age are usually thought to be associated with arteriosclerosis of the blood vessels of the brain. They are first noted in the field of memory, particularly of recent memory. There is increasing difficulty in the assimilation of new experiences and inability to grasp the meaning of a situation as a whole. A tendency to egocentrism and emotional instability becomes apparent. Stubbornness and resistiveness to change become quite marked and change to another environment usually produces marked confusion. Suspiciousness and paranoid ideas may be prominent. Sleep habits change and the patient turns night into day.

Patients in this group are not usually psychotic and should not be considered as coming under the head of the senile psychoses. They are considered here only because of their temporal relationship to this group.

SENILE PSYCHOSES

Attempts are occasionally made to distinguish between the psychoses dependent upon cerebral arteriosclerosis and the senile psychoses.

Such a distinction is of only academic interest and probably cannot be made during life. Diseases of the arteries of the brain are often found at autopsy in individuals who during their lifetime have shown no evidence of mental and nervous disorder. The principal distinction between the two conditions is that in cerebral arteriosclerosis there is a greater tendency to focal disturbances and for the condition to occur earlier.

Definition

Senile psychoses are grave somatopsychic disorders resulting from the individual's realization of his inadequate solution to the conflict being waged between his diminishing physical and psychic powers and his desire to maintain his presenile personality and position.

Etiology

The mental disorders of senility are more often the result of attitudes and habits of mind acquired during a lifetime than of the physical changes of old age.

Two factors lend substance and strength to this consideration. The first is that a good number of those who reach old age remain mentally unaffected. There is good reason to believe that the physiological changes which characterize this period do not necessarily produce the disorders of senility. Of course, in some instances the physical changes are so far reaching, so severe, that mental deterioration is inevitable, but arteriosclerotic and cerebral changes do not necessarily induce senile psychosis. The patient's habits of reacting to the stresses and strains of life, the type of personality developed during a lifetime, would seem to be equally important in the matter of etiology.

Investigation of the prepsychotic personality may also throw some light on the situation. People who have developed improper and unhealthy psychological habits of meeting problems can hardly expect to survive the hazards of old age without difficulty. On the other hand, those who have developed well-balanced personalities, whose philosophy of life and death furnishes them with a satisfactory solution to the inevitable problems of existence are certainly better prepared for old age; and, other things being equal, they can be expected to preserve normalcy.

Age of Incidence

The lower age limit of senile psychoses is usually arbitrarily fixed at about sixty years. The disorders, therefore, which appear before

that age, i.e., between the fortieth and sixtieth year, should be classified as presenile.

Clinical Manifestations

These vary greatly and depend to a large extent upon the presence of concomitant physical disease. A general slowing down of the metabolism of the body, particularly of the endocrine glands, may result in such symptoms as generalized weakness; loss of appetite; vague, generalized aches and pains; and insomnia. Evidence of arteriosclerosis is usually present.

Mental Manifestations

The degree of mental impairment varies in rough proportion to the duration of the disorder. The earliest disability noted is usually an impairment of judgment and reasoning. The changes noted above under cerebral arteriosclerosis are usually present, but to a greater degree. There is a tendency to reversal of the sleep habits. With the progression of the condition, this may become dangerous because of the harm likely to result from wandering around in the dark. There is a progressive lack of ability to concentrate, restlessness, irritability, loss of interest, a narrowing of previous fields of interest, confabulation, retrograde falsification of memory, talkativeness, confusion, and a tendency to paranoid delusions which may be grandiose or euphoric.

This delusional state is the outcome of the disturbed emotional life of the individual who, while under its sway, may commit acts of violence, be guilty of sexual aberrations and alcoholic excess. Hallucinations are not uncommon. As the condition progresses, the personality disintegration advances to a state of almost complete dementia and the individual becomes careless in dress and in personal cleanliness and finally may become incontinent.

CASE 51: Senile Psychosis

White female, age 88, widow. History from the nurses indicated that she spent most of her nights walking around the house, disturbing other patients by making noises and by invading their rooms; that each night, if given the opportunity, she placed all the furniture in her room in a pile in front of her door; that she attempted on several occasions to get out of the window; and that she was actively hallucinated and disoriented.

Mental examination revealed an aged, actively hallucinated white female who was moving about the room as if in search of something. The furniture was disarranged, the screen had been removed from

the window and the electric-light fixtures on the wall were bent, which, according to the nurses, was the result of her activities. She was disoriented in all spheres and thought that the doctor was a taxi driver, and did not recognize the nurse who had been taking care of her for some time. Her speech was rapid and repetitious, dealing mostly with the statement, "It is time to go." Her attention was difficult to get and could not be retained. She carried on this constant stream of talk with voices which seemed to come from a variety of locations. On one occasion she attempted to open the window of the room and get out. She was negativistic.

Prognosis

The condition is usually steadily progressive until complete dementia eventually develops, unless the patient dies of an intercurrent infection.

PRESENILE PSYCHOSES

The presenile psychoses are characterized by the development of the physical and mental changes associated with the senile psychoses, but at a much earlier age, usually between the ages of forty and sixty. The presenile psychoses are usually described under three headings:

1. Pick's disease,
2. Alzheimer's disease,
3. Presbyophrenia.

Pick's Disease

Clinically, this condition differs but little from Alzheimer's disease, and during life cannot be distinguished from it. Pathologically, it differs in the absence of the senile plaques found in the brain in Alzheimer's disease. There is present a circumscribed atrophy of the cerebral cortex, usually confined to the frontal and temporal regions. The upper three cortical layers are principally affected. The cause of the condition is unknown. The disease is always fatal and runs a course which may vary from four to twelve years.

Alzheimer's Disease

This condition, which is considered by some to be synonymous with presbyophrenia, is characterized by the rapid development of the changes characteristic of the senile psychoses, but at an early age. Pathologically, there is a very marked atrophy of the brain with evidence of focal necrosis. Present in the cortex are numerous "senile plaques" which are not found in any other condition.

Clinical Manifestations

These cases present at an early age period a high degree of dementia, often with aphasia and apraxia. Convulsions are not unusual. All that has been previously said of the senile psychoses is true of Alzheimer's disease. It differs only in its earlier onset and its more rapid progress to complete dementia.

Prognosis

The disease may run its course in as short a time as one year, but in some instances it has not been the cause of death for at least ten years.

Presbyophrenia

This condition, which is thought by some to represent an early state of Alzheimer's disease, is characterized principally by memory defects and a tendency to falsification of memory. As a rule, although severe memory defects and complete disorientation are present, the patient shows marked mental alertness and attentiveness. Although he is able to carry on a conversation and retain immediate impressions, his forgetfulness leads to frequent contradictions and repetition. The prognosis is hopeless, and the condition is progressive, but not as rapidly so as in those just described.

Treatment. There is, unfortunately, no treatment of value for the senile individual. There are, however, certain principles to be born in mind in handling him. Disturbance of the routine of his life inevitably leads to confusion. For this reason, as little change in his daily habits of living should be made as is consistent with his well-being. Institutional care with its regular routine gives him a feeling of comfort and security which he frequently cannot have when he is shifted from one relative to another. Special care must be given to his adequate nutrition, because, left to his own devices, he frequently neglects eating and is often seen confused and disorientated because of inadequate food and fluid intake. Confusion is most likely to occur at night. Therefore, special attention should be given to the sleeping habits of the patient, and it is best that he be not left alone at night because of the possible dangers which may arise from his nocturnal wanderings. His irritability and emotional instability are best handled by distracting the patient to some interesting activity.

PSYCHOSES WITH CHOREA

Huntington's Chorea

Definition

Huntington's chorea is a rare, familial, severe, and progressive type of chorea. Its onset is usually between the ages of thirty and forty-five, but it may occur earlier or later. Involuntary movements are the most prominent feature of chorea. These movements are purposeless, un-co-ordinated, and unsymmetrical. They follow each other in a disorderly manner. Any part of the body may be affected, although the movements are less noticeable in the lower extremities. In mild cases, speech is not affected. As the condition becomes more severe, not only speech but mastication and swallowing may be so severely affected that the patient is unable to eat. Huntington's chorea is said to be transmitted as a Mendelian dominant characteristic.

Clinical Manifestations

The condition is usually somewhat insidious in onset, and there is a gradual development of involuntary choreic movements which eventually leads to dysarthria and ataxia, with eventual inability to walk.

Mental Manifestations

A few years after its onset, mental changes slowly develop and a change of character is noticeable. Part of this may result from the fact that at this stage the patient's insight is good and he is fully aware of the distressing possibilities of his condition. As a result, he may become impatient, irascible, depressed, or excited. As in all other conditions, the prepsychotic personality of the individual plays a part in the development of his mental symptoms. If by early training he was excitable and suspicious, he may become paranoid. If he has been quiet and withdrawing, he may develop a schizoid type of picture. Suicide is unusual, although depression is common.

The classical description of the disorder as noted above is not always verified, however. For example, in some instances the mental symptoms have occurred before the choreic manifestations.

Prognosis

Except in very rare instances, the disorder is progressive, and eventually complete mental deterioration occurs. The patient usually dies between the tenth and fifteenth year after the onset of the disease.

Sydenham's Chorea

Definition

Sydenham's chorea (St. Vitus' Dance, Chorea Minor) is an acute disease of children characterized by purposeless, involuntary contractions of the muscles and psychic disturbances. It is a result of rheumatic fever and as such is frequently associated with endocarditis and polyarthrititis.

Etiology

This condition is almost twice as common in girls as in boys, occurring most commonly between the ages of five and fifteen. As noted above, it is one of the rheumatic triad and is frequently preceded or followed by cardiac and joint manifestations.

Symptoms

An important point to be borne in mind in discussing the symptoms of Sydenham's chorea is that it must not be mistaken for choreiform movements which are hysterical manifestations. With proper care, little difficulty should be experienced in distinguishing between the two conditions. In Sydenham's chorea there is always evidence of infection. During its early states the patient becomes restless, irritable, and inattentive. He soon shows evidence of in-co-ordination, which usually starts in the upper extremities. Facial grimacing is also an early manifestation. In some unusual cases the choreic movements are limited to one side of the body. The condition is then called hemichorea. In the more severe forms of the disease the patient may be unable to take care of his bodily needs because of the unco-ordinated muscular contractions. Speech may be disturbed or lost, and he may not be able to swallow.

Chorea Insaniens

Chorea insaniens is a severe form of chorea of unknown etiology which frequently appears in adult women. It occurs with greater frequency during pregnancy. All the manifestations described above may be present in an exaggerated form. The patient is frequently hallucinated, febrile, and restless. Death is not uncommon as a result of exhaustion.

Prognosis. The juvenile type of chorea is self-limited and seldom runs a course of more than six months. There is, however, a marked tendency to recurrence.

POSTTRAUMATIC DISORDERS

As has been previously pointed out, the psyche depends upon the brain as a necessary condition for its function. It is not unusual, therefore, that injury to the brain should be accompanied by severe psychic changes. However, as pointed out by Noyes,⁵ the rather prevalent opinion that injuries to the head are a frequent cause of mental disorders is an error. Less than 1 per cent of patients admitted to mental hospitals were diagnosed as suffering from posttraumatic psychoses, as that word is properly understood.

A posttraumatic psychosis may be defined as one in which the mental manifestations are directly attributable to the injury rather than merely precipitated by it. There can be little doubt that the stress associated with head injuries may be sufficient in many instances to precipitate a psychosis in one who is disposed to such a disorder. In those instances in which a manic attack or schizophrenic disorder occurs following head trauma, the psychosis would undoubtedly appear sooner or later, even though the head injury did not occur.

Head injuries are usually associated with (1) concussion, (2) contusion, and (3) laceration.

Concussion is usually associated with no demonstrable brain damage. It has been defined by Wilfred Trotter as "an essentially transient state due to head injury, which is of instantaneous onset, manifests widespread symptoms of a purely paralytic kind, does not, as such, comprise any evidence of structural cerebral injury, and is always followed by amnesia for the actual moment of the accident."⁶

In *contusion* of the brain, there can be demonstrated multiple small hemorrhages which are usually superficial.

Laceration of the brain, which may or may not occur in association with a fracture of the skull, may result in extensive brain damage.

From the psychiatric standpoint, three types of posttraumatic disorders are usually described:

1. Posttraumatic delirium,
2. Posttraumatic personality disorder,
3. Posttraumatic mental deterioration.

Posttraumatic Delirium

This condition usually occurs immediately following the injury, which may or may not be associated with unconsciousness. It is

usually associated with a disturbed sensorium, clouding of consciousness, confusion, and disorientation. The patient is usually restless, apprehensive, and anxious. His memory is impaired and he may fail to recognize old acquaintances. His speech may be fragmentary and incoherent. Hallucinations, usually visual, are not infrequent. An occasional patient is belligerent or even assaultive.

In some instances, delirium may be protracted, and in association with it, the patient may demonstrate a change of disposition and mood, becoming irritable, faultfinding, petulant, and subject to violent emotional outbursts. His adaptive capacity, initiative, and ability to concentrate are impaired. The memory defect usually persists and is associated with confabulation and a tendency to fill in the memory defects with imaginary occurrences. His ability to tolerate alcohol is impaired.

Posttraumatic Personality Disorder

This change is most likely to occur following an interval of several weeks to several months after the injury. It may or may not have been preceded by unconsciousness or delirium. The patient who is ready to resume his activities notices, or those about him realize, that he is displaying a lower degree of efficiency and that his energy output is greatly diminished. His attention is impaired, and there are defects in memory and inability to concentrate. A diffuse headache is usually present which may at times be extremely severe. This headache is usually accentuated by noise, mental effort, fatigue, and bright lights. Emotional instability is usually present and slight stimuli may give rise to extreme outbursts of rage or pain. As the mental retardation becomes more marked, spontaneous activity is greatly decreased, and mental acuity becomes greatly diminished. As might be expected under the circumstances, the patient's range of interest is greatly decreased.

The differential diagnosis of this condition in its less advanced states is difficult. The greatest difficulty arises in distinguishing it from a posttraumatic psychoneurosis. Many clinicians have attempted to formulate criteria for the differential diagnosis between these two conditions. Kennedy, whose work in this field is worthy of the most serious consideration, postulates that if headache and dizziness persist for four months in a patient under sixty years of age, "the condition should be regarded as of functional origin," if the following seven criteria of head injury are absent: (1) X-ray evidence of skull frac-

ture, (2) bloody spinal fluid, (3) bleeding from skull orifices, especially the ears, (4) cerebral palsies, (5) convulsive states proved to be post-traumatic, (6) ventricular distortions, and (7) history of prolonged unconsciousness.⁷

A chronic form of posttraumatic personality change is frequently seen in pugilists, who in the course of their training suffer repeated cerebral blows. This condition was first described by Martland⁸ under the title "punch drunk." As a result of repeated blows, it is likely that fighters suffer multiple small cerebral contusions which in the course of time lead to personality deterioration. According to Noyes, the condition has a tendency to progress for a period of about a year and then to become stationary.

Posttraumatic Mental Deterioration

This condition usually becomes evident soon after the injury, although it may not be evident if there is a protracted delirium. Protracted delirium and evidence of actual brain injury or skull fracture are not necessary conditions for its development. It may occur in the absence of all of them. The same symptoms are likely to occur as in posttraumatic personality change, but they are obvious and unmistakable. Retardation is more marked, not only in the mental sphere, but also in the physical. Memory defects are more apparent, and there is a tendency to absurd confabulation to fill in the memory gaps. Emotional blunting, defective judgment, inability to deal with abstract concepts, "a one-track mind," i.e., the inability to shift easily from one subject to another, are usually present and obvious.

POSTTRAUMATIC PSYCHONEUROSES

This term refers to the psychological and emotional disturbances that sometimes are associated with minor head injuries. These reactions are rather emotional than organically pathological.

They are to be distinguished from the psychoneuroses resulting from the severe emotional upsets accompanying extensive injury or terrifying experiences. The posttraumatic psychoneurosis is closely allied to the postconcussion syndrome seen so frequently during World War II. This latter syndrome was first studied and reported by Straus and Sovitsky, who described its principal manifestations as headache, dizziness, undue fatigue, irritability, and vasomotor disturbances, following exposure to blast.

The prominence and ease of recognition of the symptoms attributable to lesions of the central nervous system caused overemphasis to be placed on the organic nature of these manifestations in World War I. Since that time, and particularly as a result of careful study in World War II, the nature of brain injuries and their relationship to symptoms is better understood. As pointed out by Drager, Barr, and Sager, "those whose symptoms are purely psychogenic and have no organic basis are apprehensive, lose weight, eat poorly, do not sleep well and have terrifying dreams. The symptoms of those suffering from organic brain damage are lethargy, slow cerebration and lack of interest. . . . The degree of lethargy, according to O'Reilly and Gloyne, is indicative of the severity of the injury."⁹

The symptoms of a posttraumatic psychoneurosis are largely produced on the basis of anxiety. It is, therefore, to be expected, as indicated above, that the clinical picture would consist largely of anxiety manifestations. The most common of these is headache, made worse by change of position, dizziness, blurring of vision, easy fatigue, restlessness, insomnia, impotence, inability to concentrate, and preoccupation. The preoccupation may give rise to the appearance of dullness and loss of mental acuity which are not, however, usually present.

EPIDEMIC ENCEPHALITIS

Definition

Epidemic encephalitis (encephalitis lethargica, sleeping sickness) is an infectious disease of the central nervous system characterized clinically by disturbances of consciousness and various cranial nerve palsies.

This disorder is described in the official nomenclature as follows:

Here are to be listed those mental disturbances associated with acute phases of epidemic encephalitis such as delirium or stupor, and those chronic cases with demonstrable residual defects of the intellectual processes and emotions; these defects show themselves in a diminution of voluntary attention, of spontaneous interest, and of initiative; memory impairment is often slight. Apathy, depression, euphoria, anxiety or emotional instability may be found from case to case.¹⁰

Etiology

Although encephalitis in its present form has been recognized for only about thirty years by the medical profession, a disorder similar to it has been described for several hundred years. In 1712, a disease

called "sleeping sickness" appeared at Württemberg, Germany. It was characterized by inertia, drowsiness, apathy, laziness, and somnolence. Between 1889 and 1892, a very similar disease appeared in Italy, where it was given the name of "Nona."

The contemporary type of encephalitis was definitely diagnosed for the first time in Europe in 1915. In 1916, epidemic encephalitis appeared in conjunction with influenza which, however, it had preceded by several years. Von Economo and Wiesner, who first established the infectious nature of encephalitis, believed that it was due to a filterable virus. No age or sex is exempt from the disease, but it is somewhat more frequent in young males.

Symptoms

Not too much can be said as to the exact symptomatology because there is a marked variation in the manifestations shown by the disease in various epidemics.

The onset is acute in about 10 per cent of the cases; in the remainder, the symptoms develop slowly.

The characteristic symptoms are as follows:

1. Lethargy or somnolence is present in about 80 per cent of the cases. As a rule, the patient is easily aroused, but as soon as his attention is lost, he again sinks into his lethargic state. The reversal of the sleep rhythm is not unusual, and in some instances the condition is characterized by insomnia.

2. Cranial nerve involvement is very common, particularly in regard to the eyes. Diplopia, nystagmus, ptosis, and other eye symptoms are common. The Argyll-Robertson pupil may be found.

3. Fever is usually present but is of a low degree. It is associated with a tachycardia.

4. Delirium and hallucinations are common.

5. Involuntary muscular contractions in the form of twitchings, tremors, choreiform, and athetoid movements are frequently present.

6. Spinal-fluid changes are not characteristic, and as a rule the only changes noted are a slightly increased cell count, chiefly lymphocytes, and a slight increase in globulin.

7. Mental manifestations are usually present in all cases, but in varying degrees. The most common changes noted are clouding of consciousness, memory defects, delirium which may be associated with excitement of an extreme degree, change of character, and a severe depression.

Postencephalitic Manifestations

The disease is essentially chronic, not only from the clinical standpoint, but from the pathological standpoint as well. For many years after its inception it has been shown to be still active. The late manifestations of encephalitis may appear at varying intervals up to many years after the acute disease has subsided. The most common late manifestation is the appearance of the Parkinson syndrome. When young children are affected by encephalitis, they are likely to show, as a late manifestation, mental deterioration. In children, severe conduct disorders have been described.

Prognosis

The course of encephalitis varies considerably in different epidemics. The same is true of mortality. More recent epidemics have run a relatively benign course.

PARALYSIS AGITANS

Paralysis agitans was first described by Parkinson in 1817 and is frequently known by his name. It is popularly known as "shaking palsy" because of its characteristic tremor. It may be defined as a chronic progressive disease of the central nervous system, characterized by muscular rigidity, weakness, slowness of movement, and a rhythmic, spontaneous tremor. Two types are usually described: (1) the postencephalitic, and (2) the arteriosclerotic. The postencephalitic type occurs in the younger age group, and no definite pathology has been described. In the arteriosclerotic type, constant changes have been found in the large ganglion cells of the globus pallidus of the lenticular nucleus. The condition is found about twice as frequently in men as in women.

There are no characteristic mental symptoms. Varying degrees of emotional instability have been noted, but, on the whole, there is a tendency to euphoria. There is little, if any, intellectual impairment until late in the disease.

TREATMENT

Reference should be made to suitable medical and surgical texts for the standard treatment of the conditions mentioned on the previous pages.

SUMMARY

This chapter describes those psychoses usually called organic. In these conditions as in the toxic psychoses careful distinction must be made between signs and symptoms. In these conditions such a distinction is especially important because in them there is organic brain damage which interferes with normal function of the material organs, e.g., the internal and external senses. The symptoms or subjective manifestations are the result of the patient's reaction to his disease and are based on his prepsychotic personality. This accounts for the great diversity of symptoms as against the greater constancy and smaller number of signs. The effect of the organic change may be much greater in some cases than others. The treatment of these disorders should be sought in texts devoted to these disorders. Neither space nor the purpose of this text permit their treatment here.

FOOTNOTES

1. Russell Brain, *Diseases of the Nervous System* (London: Oxford University Press, Oxford Medical Publications, 1945), p. 386.
2. *Statistical Guide* (003-147) (State of New York, Dept. of Mental Hygiene), compiled by H. M. Pollock, 12 ed. (Utica, N. Y.: State Hospital Press, 1943), p. 15.
3. *Ibid.* (002-147).
4. It must be admitted that the trend of modern psychiatry is almost entirely toward somatogenic emphasis. But some recognition has been taken of the fact that a complete explanation of paretic personality must include psychic, nonorganic elements.
 A. F. Tredgold, *Psychological Medicine* (Baltimore: The Williams & Wilkins Co., 1943), p. 176.
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 Edward A. Strecker, *Fundamentals of Psychiatry* (Philadelphia, London, and Montreal: J. B. Lippincott Co., 1943), p. 62.
 R. R. Grinker, *Neurology* (Springfield, Ill.: Charles C. Thomas, 1944), p. 905.
5. Arthur P. Noyes, *Modern Clinical Psychiatry*, 2 ed. (Philadelphia: W. B. Saunders Co., 1940), p. 255.
6. Wilfred Trotter quoted by Arthur P. Noyes, *ibid.*, p. 253.
7. Foster Kennedy, "Head Injuries: Effects & their Appraisal," *Arch. Neurology and Psych.*, 27:811, April, 1932.
8. Martland quoted by Noyes, *op. cit.*, p. 259.
9. Drager, Barr, and Sager, *Journal of the American Medical Association*, Vol. 90, pp. 1281-1285.
10. *Statistical Guide*, *op. cit.* (003-165).

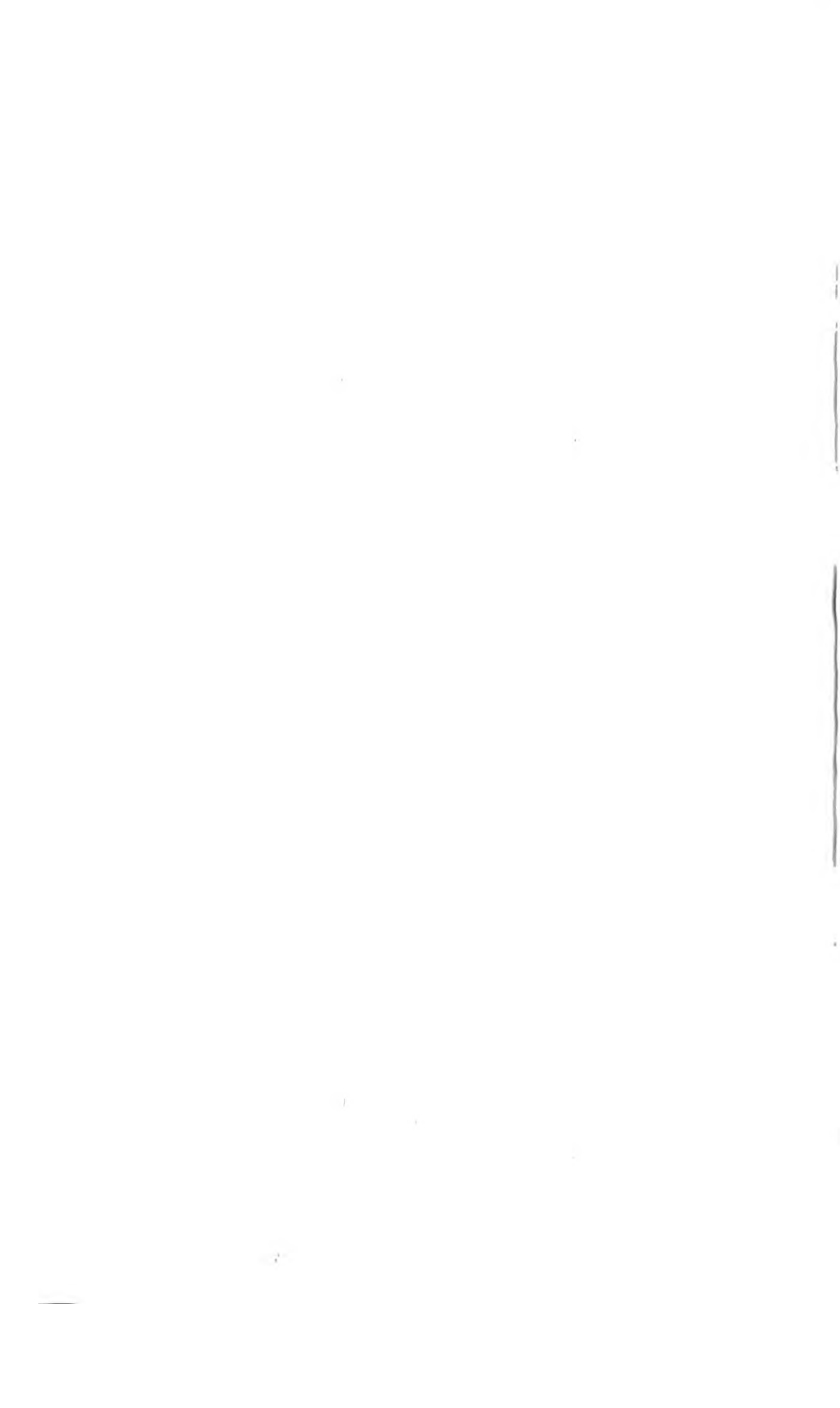
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PART VI

BORDERLANDS OF PSYCHIATRY

CHAPTER

XXVI. THE PSYCHOPATHIC PERSONALITY

XXVII. EPILEPSY

XXVIII. MENTAL DEFICIENCY

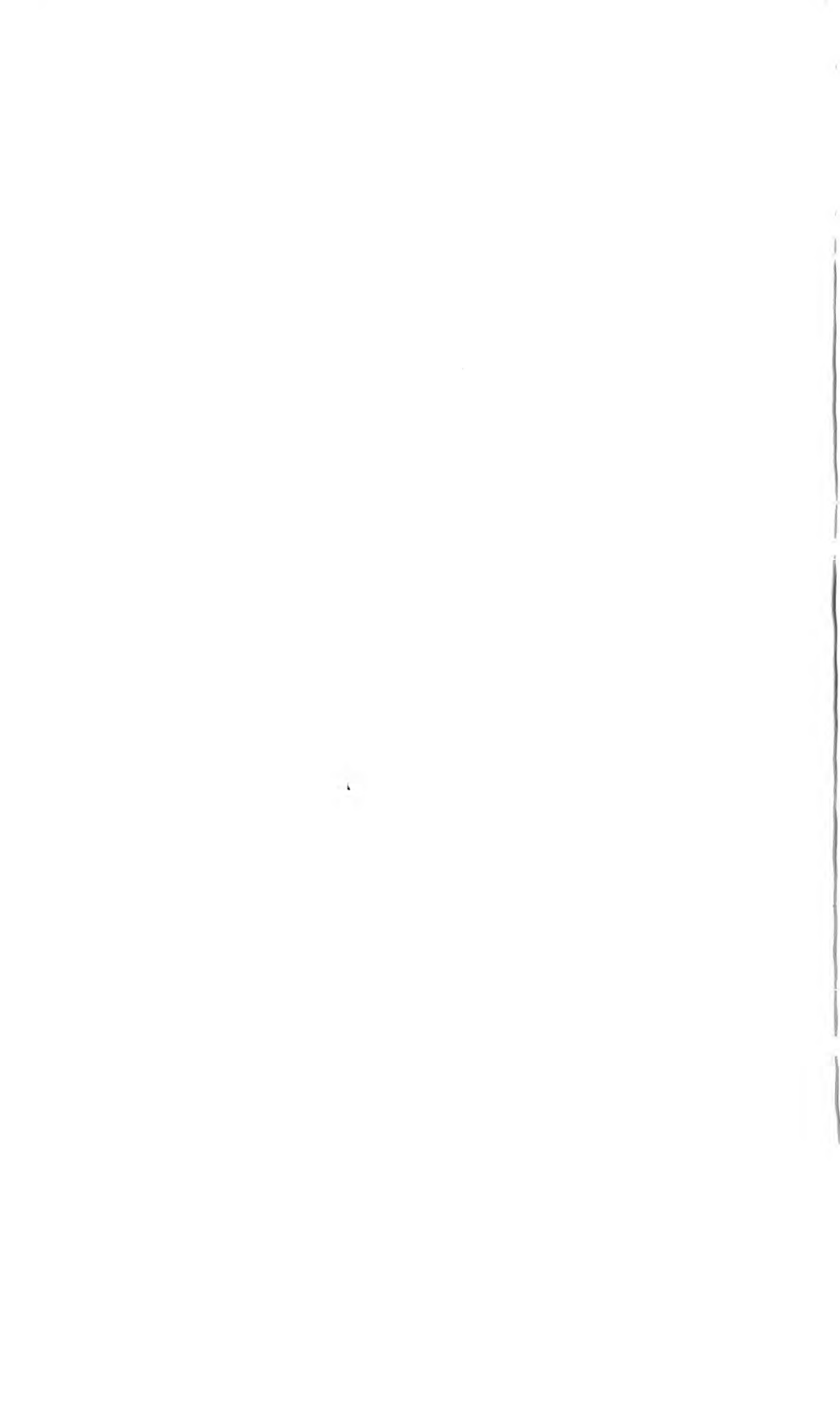
XXIX. DISTURBANCES OF SEX

XXX. HOMOSEXUALITY

XXXI. RESPONSIBILITY IN MENTAL DISORDERS

The next five chapters are devoted to conditions whose place in psychiatry is not fully determined. The psychopath comes more frequently to the attention of the law than he does to psychiatry and neither has the answer to his problem. Epilepsy is primarily a problem for the neurologist but in some aspects he comes to the attention of the psychiatrist because he so frequently presents a bizarre and typical picture. Sexual disturbances by general consent seem to be a psychiatric problem but these individuals also frequently seek for advice from others before the psychiatrist is asked to help. Every individual versed in psychiatry should be familiar with these disorders.

Mental deficiency is placed with this group because although properly included under the term "psychiatry" it does not belong in dynamic psychiatry because it is usually based on defect state.



THE PSYCHOPATHIC PERSONALITY

DEFINITION

Various names have been employed to designate this character distortion: *constitutional psychopathic inferiority*, *psychopathic personality*, *moral imbecile*, *moral insanity*, and *sociopath*. Cleckley,¹ in his exhaustive analysis of "the forgotten man" of psychiatry, feels justified in offering a new terminology. He prefers the name of *semantic dementia* which refers to a condition of mind or of a personality so undeveloped that it is incapable of utilizing experience as a whole. Cleckley's work on the psychopath is one of the best and most thorough that has been made. However, until his suggestion meets with wider acceptance, it will be preferable to retain the nomenclature used by the American Psychiatric Association and to speak of psychopathic personalities or psychopaths.

Psychiatrists hold many differing opinions about the psychopath. There is considerable difference of opinion as to just what constitutes the psychopathic personality. Following are *some of the definitions* given:

1. *American Psychiatric Association*

Psychopathic personalities are characterized largely by emotional immaturity or childishness, with marked defects of judgment and without evidence of learning by experience. They are prone to impulsive reactions without consideration of others and to emotional instability with rapid swings from elation to depression often apparently for trivial causes. Special features in individual psychopaths are: Prominent criminal traits, moral deficiency, vagabondage, and sexual perversions. Intelligence as shown by standard intelligence tests may be average or superior, but, on the other hand, not infrequently a borderline intelligence may be present.²

2. In the "Outline of Neuropsychiatry in Aviation Medicine," published by the War Department, the following definition is given:

Psychopathic personality is the term applied to various inadequacies and deviations in the personality structure of individuals who are neither

psychotic nor feeble-minded, the defect existing particularly in the conative, emotional, and characterological aspects of the personality.³

This definition is similar to that given by Noyes.⁴

3. Henderson,⁵ in *Psychopathic States*, says that the term is applied to individuals

- a) of generally good, but sometimes inferior, intellect
- b) who from early youth,
- c) exhibit periodic antisocial conduct
- d) and who fail to respond to ordinary treatment.

The pictures presented by psychopathic personalities are almost indefinitely variable. The following definition would seem to be fairly satisfactory: *Psychopaths are individuals with deficient personalities due to defective character organization with lack of insight.*

EXPLANATION OF DEFINITION

1. The term "psychopathic" has been used to indicate general states of mental disorder, but such is not its present significance. Psychopathy does not connote psychosis, although the two states may be found together. The American Psychiatric classification of mental disorders lists psychopathic personality with or without psychosis.

2. Psychopathy is considered by many as a manifestation of a neurosis, in which the patient, instead of demonstrating somatic manifestations, expresses his symptomatology in antisocial conduct.

3. The psychopath is not mentally defective; his stupid, bizarre, or otherwise unintelligible conduct proceeds from causes other than defective mentality.

4. Defective character organization; the peculiar conduct disorders that characterize psychopathic personality are apparently due to defective control of the will. At some point, the psychopath has failed to develop that dominance of will power over emotions, thought, life, and conduct which we call character. As Cleckley⁶ indicates, *psychopaths are lacking in insight*; i.e., they have no ability to see themselves as others do and, despite their apparently normal exterior, are incapable of grasping or utilizing the experience of life.

ETIOLOGY

Incidence

The number of psychopaths is considered by some to be appalling. Certainly their presence in the general population is much greater than is ordinarily supposed. It must be admitted that in the present state

of knowledge it is impossible to know what percentage are psychopaths. There are no institutions for psychopaths. Occasionally, due to special circumstances, these unfortunates find their way into asylums for the insane, but they do not often remain there long.

Cleckley⁷ tells of a study of 857 new admissions to a psychiatric hospital. One hundred and thirty-nine were classed as psychopaths, but after closer study of the data, he felt justified in considering 266 or more than one fourth of the entire number as belonging to this class.

In a study of 1063 Naval offenders only 21 psychopaths were found, whereas in a study of Army offenders by Rottersman, the opinion was expressed that they were all basically, at least, psychopathic personalities. In other Army studies, according to Dunn,⁸ Baeter found 75 per cent of a group of deserters to be psychopathic, and Osipor found 40 per cent of the military prisoners in the Russian Army to have psychopathic personalities. Blackman found 39 per cent of a group of military prisoners to have psychopathic personalities. These studies have little scientific value because of the widely different concepts of psychopathy maintained by the investigators.

In searching for the factors responsible for psychopathic personality, it is not necessary to seek the explanation of the presence of the numberless anomalous emotional, pseudo-neurotic, and conduct disorders. The quest is for the cause of the character deformation, and the basic inability to see oneself as others do and to understand his relationship to reality.

Heredity

Hereditary constitutional inferiority and vague familial taint have been appealed to as causes. Often when causation is obscure, heredity is invoked. Heredity plays no role in the production of the psychopath. Often these character deviates belong to the best families. Moreover, the psychopathic personality is clearly a nonbiological entity that cannot enter into the hereditary process.

PSYCHOGENIC ORIGIN

While there is some basic agreement in definition, there is very little agreement in regard to the underlying psychopathology as it is described in the current literature. Weiss and English, in discussing this subject says, "The psychopathic personality has suffered great emotional deprivation in the early years of life, in a manner more similar to the psychotic than the neurotic. In later life such a person

pays society back with hate and indifference and unwillingness to understand and conform. . . . the psychoneurotic expresses his hostility in somatic symptoms. . . . the psychopath in anti-social behavior."⁹ Darling,¹⁰ as a result of his review of available literature, was inclined to believe that the consensus of psychiatric opinion would indicate that this condition was due to defective superego development.

Kraines, who refers to the condition as "hardly more than a wastepaper basket in which are cluttered various groups," states that, "the psychopathologies seem to center about an intense feeling of unrest, which can best be satisfied by, or, rather the tension of which can best be relieved by, some markedly disapproved action or some anti-social action."¹¹

The War Department "Manual of Psychiatry in Aviation Medicine"¹² states,

It is the result of intra-psychic conflict which the individual is trying to solve through adjustments that are socially inadequate or destructive. His behavior is the expression of conflict, unconscious motives and strivings. In this way, the psychopaths closely resemble the psychoneurotics. Their intra-psychic conflicts are probably the same. The psychoneurotic expresses his conflicts symbolically through his symptoms, as compared to the psychopath, who expresses these same conflicts through his irrational, anti-social, and hostile behavior.

Therefore, as Noyes states,

It will be seen that it is preferred to look upon the psychopathic personality as the product of dynamic psychological forces, rather than as the result of an innate constitutional condition; that is, in the psychopath these psychological mechanisms lead not to a more or less isolated character trait, as seen in persons pragmatically regarded as normal; or to a definite symptom, as in the neurotic, but to the establishment of dominant patterns of character, temperament, emotion and conation, which lend their imprint to the whole personality and its behavior expressions.¹³

Muncie¹⁴ devotes but little space in his textbook to this subject and describes no specific psychopathology, but includes psychopathic personality in his description of "Defect States."

White,¹⁵ in discussing the subject, mentions inadequate development of the superego, powerful instinctive drives, and the persistence of childhood standards of conduct.

Strecker says,

Constitutional psychopathic inferiority is as much a defect state as is feeble-mindedness. . . . One cannot go much beyond the statement that there is a constitutional lack or deficit, possibly an arrest of the emotional maturing processes. Psychopathologically there is a picture of decided overcompensation for inner inferiorities.¹⁶

It would seem that in the psychopath there is an inability to store tension within the personality, so that, instead of being able to build up tension, as in the normal individual and direct it toward a useful end, these tensions in the psychopath are dispelled impulsively and unpredictably. The psychopath cannot build up a store of energy for future use.

The role of parental inefficiency and broken lives in the development of the psychopath is difficult to evaluate but is present with very great frequency as in the following case:

CASE 52: Psychopathic Personality

This 19-year-old boy was admitted to the hospital because as he himself stated, he was "always in trouble." He had been a chronic disciplinary problem with a series of infractions, ranging from refusal to work to assault with a deadly weapon. His behavior was characterized by impulsiveness and an apparent inability to distinguish between right and wrong. He was easily angered and had a violent temper; just as readily, however, he reverted to a pleasant, docile, emotional state. Numerous disciplinary actions had not affected him. Physically, he was found to be a small individual of athletic build, in excellent health. Mentally, he was clear, bright, and alert, with no abnormalities of thought. He came from a home in which there was constant discord between the parents and children. The patient stated that he disliked both his parents, and that he had divorced himself completely from his family.

Review of his background reveals psychopathic trends from earliest childhood. He was a "problem child" at home; was truant and finally expelled from school in the sixth grade; and was then engaged in gang activities and various forms of juvenile delinquency until the time he entered the military service.

In the hospital he was aggressive, boisterous, meddling with patients and staff members, and a continual ward disciplinary problem.

TYPES OF PSYCHOPATHS

1. The classical division of psychopathic personalities, made by *Kraepelin*,¹⁷ has been accepted by many authors. He distinguishes

seven types or classes of psychopaths: the *excitable, unstable, impulsive, eccentric, liars, swindlers*, and the *antisocial and quarrelsome*.

2. Kahn,¹⁸ in his distinguished work, adds the *nervous, anxious, sensitive, compulsive, hyperthymic, depressive, moody, affectively cold, weak-willed, sexually perverse, hysterical, fantastic, and cranks*.

3. Henderson,¹⁹ distinguishes three general classes of psychopaths:

a) The *predominantly aggressive*, including those who are homicidal or suicidal, addicts of alcohol and drugs, epileptoid, and sex perverts.

b) The *predominantly passive or inadequate*, including those who are criminals, liars, swindlers, erratic, hypochondriacal, sensitive, shy, excitable, hysterical, neurasthenic, and cycloid.

c) The *predominantly creative*, which includes variations of so-called psychopathic genius.

4. Strecker and Ebaugh²⁰ include *paranoid personalities, kleptomaniacs, pyromaniacs, hobos, and malingerers*.

As is clear from the above, manifestations of the psychopathic personality do not easily lend themselves to classification. After presenting these and other attempts at typing the psychopath, Cleckley²¹ truly states that the further multiplication of types and subtypes does not help to understand the psychopath.

The infinitely variable psychopath, by reason of his serious deficiencies, exhibits at one time a predominant social trait, at another time some outstanding neurotic characteristic, but, as such, the psychopath has a character defect. Pyromania, kleptomania, epilepsy, hysterical states, and other conditions are accidental to the psychopathic state as such and do not offer sufficient grounds for differentiation.

CASE 53: Psychopathic Personality

Frank was always a rather unstable and unreliable personality. These character deficiencies became more pronounced as years passed by. He was third of a family of three children, all physically normal. Frank's brother and sister have become successful and capable citizens. The entire family were devout Catholics. Frank decided at the end of high school that he would like to be a priest and joined a well-known congregation. After two years he transferred to another organization and in a few years dropped all study for the priesthood. He married soon after. Two children were born of this marriage. His wife, a rather simple and naïve sort of person, soon learned that she was married to a man capable of the most irresponsible, unpredictable behavior and unbelievable infidelity.

He was physically most attractive and biologically perfect. He was

intelligent and likable. He had earned an A.B. and an M.A. and was intellectually capable of more advancement. He was a smooth and convincing talker. Soon after taking a position in his home town, his wife and mother were horrified to learn he had passed numerous worthless checks. They spent everything they had to protect him. He took a traveling salesman's job. In a short time he had married four girls in four different towns and had given them all his correct home address. His home was swamped with wires and letters of love and complaint from his scattered wives. He wrote more bogus checks. He participated in shady deals. He neglected his wife and children. Finally friends and relatives forced him to leave home and go West.

One day he unexpectedly appeared at the home of an acquaintance in a Western town. In a short time his newly acquired friends were holding thousands of dollars worth of bogus checks. An old aunt had a few thousand dollars left by her husband to care for her until death. One night he borrowed the money and, in a few days, spent it all on wild schemes. He left the old lady penniless. Soon social agencies complained that he had abandoned his wife and two children. In the meanwhile he was planning another marriage. He borrowed his intended wife's car and hurriedly visited his four wives scattered in Midwestern towns. His forgeries and other dishonest dealings began to catch up with him. His first wife sued him for divorce. It seemed apparent that he would soon be arrested so he deemed it advisable to leave, and did so. However, at his new destination his first worthless check landed him in jail, from which he wrote piteous, unavailing pleas for help. He was soon released, left town, and started another train of marriages and forgeries. He was drafted by the Army and all trace of him has been lost.

This is only a very incomplete record of Frank's activities. He evinced at times astounding versatility, was absolutely unpredictable and almost entirely unreliable.

Psychopaths look just like normal people, but the similarity is very much on the surface. However, it accounts for the increased difficulty in comprehending this type of deviation. People unfamiliar with the eccentricities and the many-sided character deficiencies of the psychopath are shocked, hurt, and amazed time after time by their consistent, often socially painful, misbehavior.

SYMPTOMS

The manifestations of the psychopathic personality are of an almost infinite variety. They cannot all be recognized here, but some stand out more than others and are more commonly present.

1. *Faulty personality organization.* In the normal personality there is a balancing of faculties and powers; there is some control of the emotional and mental life; there are some motivating ideals and there is orderly subordination and control, but not in the psychopath. *He has the raw materials of personality, but the power of synthesis or organization is wanting.* In fact he seems possessed of a genius for the opposite. With him, the lack of character organization is not merely negative. It is positive. He is organized, but along the wrong lines.

2. *Egocentricity.* The psychopath is *incredibly selfish*. His selfishness is shortsighted. For immediate gains and satisfaction he ruthlessly, but often cleverly, sacrifices everybody but himself. He has an unbelievable lack of real affection for friends and loved ones. He is a source of pain to his family. The realization of this does not disturb him. He selfishly demands again, often and without shame, and seems to be incapable of gratitude and appreciation.

3. As has already been indicated, *psychopaths are seldom lacking in intellect* and usually are *not insane* in any ordinary sense of that word. But, as Cleckley has pointed out, they should be considered frankly "psychotic," not as that word is customarily used but in the sense that *they are wanting in insight*. This lack of insight expresses itself in a hundred different ways, but especially in their inability to comprehend the purposes and meaning of life activities and their own experience.

4. The English consider this class of patients as moral imbeciles or morally insane. In some regards they seem to have a defective moral sense. They are *liars, pathologically dishonest, and sexually promiscuous*. Furthermore, they do not seem to comprehend the immorality of their behavior. They fornicate, practice adultery, steal, lie, cheat, and swindle shamelessly and without compunction. Their standard of morals seems to be personal utility and nothing else. "What is good for me is morally good."

5. *Irresponsibility.* The psychopath is *wanting in good judgment, highly undependable, and absolutely irresponsible*. He will say or do the wrong thing. Because of lack of insight and lack of the ability to comprehend the true purpose of things and because of his shortsightedness and selfish interpretations of situations, the psychopath is unable to manage himself or his affairs prudently. He is perhaps able to perceive the means necessary to the end desired, but seems not to fully comprehend the relationship. This, in addition to his

moral outlook and essential dishonesty, renders him highly unreliable and irresponsible.

6. *His conduct is erratic, unpredictable, and often outlandish and fantastic.* It is difficult or impossible to tell what he will do next. It is especially under the influence of alcohol that he carries on in unbelievable style. Most psychopaths are easily affected by alcohol and often small amounts suffice to upset them profoundly. Under the influence of alcohol, their true colors show themselves and their deficiencies are made more manifest.

7. *Psychopaths are incapable of learning by experience.* Most people make mistakes, fall into error, but normal people characteristically profit by their mistakes. The psychopath does not. He will repeatedly run the same risks, knowing full well the consequences of his acts. This is a symptomatic manifestation of his underlying inability to grasp the purpose of things.

8. *The psychopath is typically devoid of interest in the future.* He has no definite goal beyond the immediate satisfaction of the moment. He has no fixed plans of life. He has no interest in the future. Today's shortsighted satisfactions are paramount.

9. *The sex life of the psychopath is abnormal,* not so much in the sense of perversion as of promiscuity and moral obtuseness. Most authors speak of the sexual psychopath. Most psychopaths suffer from habitual disordered sexuality.

The psychopath presents an infinitely variable, kaleidoscopic picture. He is baffling. He has been and is still but little understood. No provisions have been made for him in society. He cannot live in the community or does so with greatest difficulty and inconvenience to all. He cannot enter psychiatric hospitals because he is not insane. The school he attends, the family from which he emanates and with whom he lives, his friends and neighbors, the police, the jury, the jail, the hospital—all fail to understand him or provide for him.

CASE 54: Psychopathic Personality

This 17-year-old male was admitted to the hospital because of restlessness and inability to adjust to military life. He was in continual trouble while in the military service during the war and was frequently in disciplinary difficulties.

Observation revealed him to be good-natured and likable, but restless and mildly confused. His behavior was characterized by impulsiveness and a notable lack of moral conscience. In discussing many of his delinquencies, he stated that he did not believe

them to be wrong. He committed his misdeeds on impulse and seldom thought about them afterward.

His family and past personal history revealed no distinct neurotic traits but did show considerable social pathology. The patient's father deserted the family when the patient was nine months old. His mother, who was chronically ill, was forced to relinquish the patient into the custody of a child-placing agency and later to a foster home. The foster parents were described as "good Christian people" who attempted to properly supervise and discipline the patient but were unable to devote much affection to him since they also cared for six other unrelated children. From earliest childhood the patient was uncontrollable and a disciplinary problem. He stole money, was destructive, and mischievous and was frequently a sex problem. At the age of nine he attempted a sexual assault on his foster sister; at ten years of age he was expelled from school because of sexual approaches to his teacher; and at fifteen years of age he admitted having raped a minor girl. He ran away from home at the age of twelve and wandered around the country riding freight trains and occasionally working at odd jobs. He was arrested several times for stealing and was in jail "fifteen or sixteen" times for vagrancy. At the age of fifteen he enlisted fraudulently in the Navy after lying about his age. He described all his delinquent acts freely and pleasantly and expressed no guilt about any of them.

PSYCHOTIC EPISODES

Transitory psychotic episodes, which may vary from states of mild confusion to acute maniacal attacks, not infrequently occur. They are most frequent when the psychopath's freedom of activity is greatly restricted, as it must frequently be aboard ship or in prison. Many of these episodes are schizophrenic in type and may easily be mistaken for that condition. The psychopath, however, makes a quick and complete recovery to his former personality level. Carefully taken histories will frequently help to differentiate such mixed pictures.

LEGAL RESPONSIBILITY

See page 561.

PROGNOSIS

The prognosis for this type of patient is apparently hopeless as far as changing his personality is concerned. No treatment as yet discovered has any effect on the course of the disease. Protection of society by institutionalizing the psychopath, if this is possible, seems the best

measure offered to date. Punishment is ineffective except that if it is in the form of confinement it removes the psychopath from society for a short time. Time alone seems effective as a therapeutic measure and in many instances the psychopath begins to change in middle age and frequently settles down as a useful citizen in his later years.

Cases of adolescent psychopathy have rarely reacted favorably to disciplinary measures. Luella Cole,²² however, tells of a 16-year-old high school boy who manifested a definite psychopathic disposition. War was declared and he falsified his age and joined the Army. Rigorous Army discipline counteracted his psychopathic tendencies. He later returned to the same high school and gave clear evidence of the personality reformation that had taken place; he graduated from high school, went to work, and apparently caused no further difficulty.

TREATMENT

There is no specific treatment. If practical, institutional care for the psychopath, while of little value as a curative measure, would save the family and the community much grief. According to Terhune, "They do best on a farm as far as possible from a large city, leading a semi-solitary existence, occupied in some more or less satisfactory undertaking."

When, fortunately, such an individual is so situated that he is under close personal supervision of one whom he likes or admires, his baser characteristics may not develop. He may then accomplish some very definite good. By working under close supervision, his greatest difficulty is avoided, namely, his inability to make his own decisions. His decisions being made for him and his work planned and suited to his capacity, he escapes the stress and strain which would otherwise cause his downfall.

There is little that can be done for the psychopath in the military service. The boredom and tedium of military existence are more than he is able to take. As might be expected, the aggressive psychopath does well in combat. As far as the military services are concerned, the separation of the psychopath from them by the most expeditious means is the best disposition.

FOOTNOTES

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EPILEPSY

DEFINITION

There is no really adequate definition of epilepsy. Under this term are included many diverse conditions whose exact relationship to each other has not been fully worked out. *Epilepsy is a condition of unknown etiology characterized by attacks of loss of consciousness, often by convulsive seizures, and by amnesia for the attack.* Although the difficulty of an adequate definition is admitted generally by writers on the subject, each one has offered a definition of his own. Cobb gives the following definition:

A disorder of the brain that causes repeated fits in which the usual functional abnormalities are: (a) changes in the electrical potentials as seen in the electroencephalogram; (b) partial or complete loss of consciousness; (c) nervous discharge into smooth muscle, striated muscle or glands, causing involuntary visceral or motor behavior.¹

Gibbs and Lennox² have suggested that the term "epilepsy" be discarded and the term "paroxysmal cerebral dysrhythmia" be used in its place, because a disturbance in the electrical activity of the cortex is common to all forms of the condition.

According to Brain,³ epilepsy is a paroxysmal and transitory disturbance of the functions of the brain which develops suddenly, ceases spontaneously, and exhibits a conspicuous tendency to recur.

ETIOLOGY

Incidence

Epileptic variants are the most common of all disorders. It is estimated that there are over one-half million people suffering from these disturbances. Lennox⁴ says that in addition there are about six million people affected with headache (migraine) seizures. He also ventures the opinion that there are probably ten million people who are predisposed to some type of seizures. Less than 5 per cent of those seriously affected are in institutions. More males than females suffer serious epileptic disorders, but it seems that more females are prone to petit mal seizures. Epilepsy is found everywhere; no race or level

of culture is immune. Some patients have only two or three seizures in a lifetime; some have a great number. Lennox⁵ had a patient who suffered 25,000 seizures a year for four years, and another who endured 210,000 seizures (20 a day) over a period of twenty-nine years.

Age at Onset

The onset of the disorder occurs in three fourths of all cases under the age of twenty. About one half of the cases begin during the second decade of life. According to Patrick and Levy, 40 per cent of these children who subsequently develop epilepsy have epileptic seizures or at least have convulsions in infancy or early childhood whereas only 4 per cent of normal children have such convulsions.

Inheritance

Brain⁶ reports that in a series of 200 epileptics, a family history of the disease was present in 28 per cent, and states that probably not more than 10 per cent of the children of epileptics develop epilepsy. Recent studies with the electroencephalograph seem to indicate that about one person in ten has some disturbance of the brain-wave pattern. The significance of this, while not fully understood, is assumed to indicate a predisposition to seizures or an allied disorder. In spite of the prevalence of disturbed brain-wave patterns, only 1 person in every 200 does have seizures. Lennox through an analysis of histories of more than 12,000 near relatives of epileptics and through recording the brain waves of 400 relatives and 100 healthy or epileptic twins discovered that among the patient's near relatives approximately 1 in 40 was subject to the seizures, and 1 in 2 had some disturbance, usually slight, of the brain-wave pattern. It can be said that epilepsy is found about five times as frequently among the relatives of an epileptic as among the general population and irregular brain waves about one hundred times as frequently. In other words the chance that the average person will have an epileptic child is about 1 in 200, while the chance that an epileptic will have such a child is about 1 in 40.

Precipitating Factors

Little is known of the actual precipitating factors in cases of idiopathic epilepsy. They have been blamed on many things, particularly trauma, metabolic upsets, endocrine factors, allergy, and psychological factors. According to Brain, "There is little reason to believe that epileptic attacks as distinct from hysterical fits are ever purely psycho-

genic, though the first fit is often ascribed to fright." During the war many cases of epilepsy were noted and the first attack that the individual experienced was while undergoing the stress of combat or perhaps in some cases only the stress of being in a dangerous area. In women there seems to be a rather direct relationship between the menses and epileptic seizures, the seizures coming just before the onset of the menses.

Signs and Symptoms

It is very important to distinguish between so-called *symptomatic* and *idiopathic epilepsy*. The former is considered to exist when the seizure is assignable to some definite pathology of the nervous system, e.g., trauma, scar, tumor, or disease. All other disorders of this type of unknown etiology are classified as idiopathic (genuine, essential, cryptogenic). In order to establish the presence of idiopathic epilepsy all possible organic reason should be first excluded. So great are the number of possible organic causes that some feel that all epilepsy should be classed as symptomatic. Others feel that all cases are idiopathic and that the scars, tumors, and traumas which are considered causal only precipitate seizures which have more radical and unknown causation.

Mental Picture

There is no typical mental picture of epilepsy, although many attempts have been made to describe the so-called epileptic personality. As can be seen in Figure 1, the personality of the epileptic is likely to be quite varied, depending upon the preponderance of physical and psychogenic factors. The typical epileptic facies is characterized by low forehead, bushy eyebrows, and glaring expression; it is seldom seen except in deteriorated patients. The personality traits usually described in the epileptic of egocentricity, emotional instability, and excessive irritability are not universally present.

Principal Manifestations

The three principal clinical manifestations of epilepsy are:

1. Grand mal seizures,
2. Petit mal seizures,
3. Epileptic equivalent or psychomotor seizures.

GRAND MAL

The grand mal attack, which is the best known of epileptic seizures, usually follows a pattern characterized by the following steps: (1)

aura; (2) cry; (3) loss of consciousness; (4) tonic convulsion; (5) clonic convulsion; (6) stupor; (7) headache; and (8) amnesia for the attack.

Aura

The *aura* or warning of an attack occurs in about three fifths of all cases, according to Gowers. It is produced by the beginning of the epileptic discharge and, depending on the site of origin of the discharge, may produce certain characteristic symptoms. In those cases not having an aura, the attack hits the patient without warning and he becomes unconscious. The aura may take the form of a complex mental state and be associated with hallucinations which have a tendency at times to be microptic. Another type of aura is an inexplicable fear as a result of which the patient may start to run (cursive epilepsy). The aura may be referred to any one of the special senses, such as olfactory, gustatory, auditory, or visual, and may consist of bright flashes of light, sparkles, scotomata, odors, and paresthesias. Vertigo is a common aura. There may be a strong desire to speak and inability to do so. The aura is usually short in duration and is immediately followed by unconsciousness.

Cry

A high percentage of major seizures are *initiated by a characteristic high-pitched cry*, which is caused by the sudden expulsion of air through a narrowed glottis caused by the beginning of the tonic convulsion. It is usually a high-pitched squeal.

Convulsion

The best known of the various manifestations of epilepsy is a grand mal seizure. Gower's original classical description of a convulsion cannot be improved upon. The convulsion can best be described in his own words:

At the onset of the severe fit the spasm is tonic in character, a rigid violent muscular contraction, fixing the limbs in irregular positions. There is usually deviation of the eyes and rotation of the head toward one side, and this rotation may involve the whole body, and sometimes causes the patient to turn round, even two or three times. The tonic spasm involves the muscles of the chest and abdomen. The features are distorted; the face, usually at first pale, becomes suffused and then livid, as the chest is fixed and respiratory movements are arrested. The eyes are open or closed; the conjunctiva is insensitive; the pupils dilate widely

as cyanosis comes on. As the spasm continues, it commonly changes in its relative intensity in different parts, so that slight changes in the position of the strained limbs occur. Presently, when the cyanosis has become intense, the fixed tetanic contractions of the muscles can be felt to be vibratory, and the vibrations increase to slight visible remissions. As these remissions become deeper, the muscular contractions become more shocklike in character, and the stage of clonic spasm is reached, in which the limbs, head, face, jaw, and trunk are jerked with violence. In the resulting movement of the chest, air is expelled from the thorax, and bloody saliva is frothed out between the lips. The air entering the lungs is at first insufficient to lessen the lividity, and the patient may seem to be at the point of death. But as the intervals between the shocks of spasm lengthen, and the remissions become greater, more breath enters the chest, and the lividity lessens. In becoming less frequent the muscular contractions do not become less strong, and the last jerk is often as violent as those which have preceded it. At last the spasm is at an end, and the patient lies senseless and prostrate, and usually sleeps heavily for a time, and then can be roused. Urine frequently and faeces occasionally are passed in the fits.⁸

It will be noted that the convulsion consists of two phases: (1) the *tonic phase* during which the muscles are rigidly contracted; and (2) the *clonic phase* during which a jerking contraction of the muscles takes place.

Stupor

After the convulsion has ceased, the patient remains in a stuporous condition for a variable length of time. Ordinarily this period would be from 10 to 30 minutes. During this stage he may perform automatic actions which seem to some extent purposeful and in a few instances his activities may be converted into a furor in which he may commit horrible crimes. When he begins to awaken from this stupor he appears confused and may be disoriented for varying periods of time.

Headache

As he begins to come out of the stupor, he invariably complains of a severe headache which in many instances will last as long as 24 hours.

Amnesia

The amnesia for the epileptic seizure starts with the onset of unconsciousness which follows the aura (when this occurs) and persists for a time following the seizure. While the onset of the amnesia is

abrupt with the beginning of the seizure, its termination has rather "fuzzy" edges and depends on the depth and the duration of the stupor which follows the convulsion.

PETIT MAL

Petit mal is a term applied to epileptic seizures in which loss of consciousness is the principal manifestation. In some patients, beside the loss of consciousness and amnesia for the attack, there is momentary loss of motor control or cataplexy, and the patient may fall or lose his balance. In the attack he usually stares into space and is oblivious to his surroundings. The attacks are frequently described by the patient as "blacking-out spells" and may occur with considerable frequency. This is especially true in children where the attacks may occur from a few to forty or sixty a day or more. Transitory pallor usually accompanies the attack of petit mal and in some instances incontinence of urine may occur, although this is not usual. After the momentary period of unconsciousness the patient usually carries on as though nothing had happened, although there will be occasional short periods of confusion following the attack. Pyknolepsy, which is the term usually applied to petit mal seizures in children, is thought to disappear with adolescence and not to recur. Gibbs and Gibbs,⁹ however, feel that pyknolepsy cannot be distinguished from petit mal in any way, except for its disappearance during the period of adolescence. They point out that this might not be a real difference, because petit mal in childhood has a tendency to change to another form after the age of puberty. Another study showed that every third patient with petit mal later developed grand mal attacks.

CASE 55: Petit Mal Epilepsy

E. P., age 12. Chief complaint was "fits" during which he lost consciousness. The patient began to have "spells" several years ago. He had two the first day, and one each month since that time. For a few days prior to admission to the clinic, however, the attacks had increased in frequency, and he had eleven in three days. The attacks began with a sensation of nausea and a feeling that cold air was passing over his body. He would feel cold and begin to shake, at this point losing consciousness for about one to one and a half minutes. He had a convulsion with the first attack, but has had none since. During the attack he was described as appearing dazed. His eyes were fixed and staring; his lips turned blue. During this period he responded slightly when his name was called, but would not

answer. After the attack, he felt quite well, had no headaches, but realized that he had experienced some sort of attack. One maternal aunt began to have epileptic fits at the age of 45. He is an only child, and was described as "nervous and high strung." Physical examination was essentially negative.

EPILEPTIC EQUIVALENT (PSYCHOMOTOR SEIZURE)

In these seizures the patient does not lose consciousness and instead of a convulsion, he performs co-ordinated although frequently purposeless movements. The duration of the attack is indefinite, although it usually lasts from a few seconds to several minutes. In some instances, the attacks have been much longer in duration. Although the patient's activity during the seizure is frequently well organized and apparently purposeful, he has an amnesia for these acts. With the advent of sodium pentothal narcosynthesis, this amnesia becomes explorable. During these attacks the patient's activity may become so violent as to amount to a furor and acts of violence, including murder or assault, may occur. Fortunately, the electroencephalogram provides a satisfactory method of diagnosing the condition, and it has in the past been used as a defense for crimes of violence when there was little but the verbal testimony of witnesses which could be used as proof of the epileptic origin of the disease. Since epileptic brain waves may occur in a high percentage of individuals who have never had an epileptic seizure, the presence of these waves is naturally not absolute proof of the occurrence of an equivalent, but the occurrence of these waves adds corroborative evidence which has been greatly lacking in the past.

CASE 56: Epileptic Equivalent With Furor

A. C., age 20, married. This patient was brought to the hospital in a confused state, having an amnesia for all the events of his past life. The day after admission his confusion had cleared, but he was still amnesic for all events, including his name. He was given sodium pentothal in an effort to break the amnesia which was done successfully, and he related that about one month before he had met a girl downtown with whom he had gone to the City Hall where they were married. Under sodium pentothal he recalled that on the evening of their marriage a man had knocked on their door at the hotel; for some reason he thought the man was making an effort to be intimate with his wife, and he had a sudden violent attack of temper and stabbed the man with a knife which was handy. He and his wife then left the room, leaving the man on the floor

bleeding. Shortly thereafter a man had spoken to his wife on the street, and he again had a sudden violent outburst and attacked him, knocking him down. He recalled also under sodium pentothal that he had struck his wife on a number of occasions. After several sessions with sodium pentothal, he was able to recall all of the events of his past life, except those which occurred in a period of rage.

While under observation he was extremely pleasant and agreeable, except for short periods every few days when he showed an increasing irritability, and he would then, on the slightest appearance of anyone crossing him, even to bump against him in the passageway on the ward, violently and in an almost purposeless manner flail his arms around in an attempt to strike at the object which was obstructing his passage. During these attacks his eyes would be open and staring and have what was described by the ward attendants as a "wild look." On two occasions while under observation he had typical grand mal attacks. His electroencephalogram showed a typical pattern for psychomotor seizures. The appearance of unprovoked assaults on those near and dear to the patient should always bring to mind the possibility of an epileptic furor.

The following is a case report in which the seizures had persisted for five years before help was sought.

CASE 57: *Epileptic Equivalent With Furor*

E. F., white male, age 26, married, came for observation at the request of his wife because of attacks of unprovoked fury for which he professed an amnesia. He had been married for about five years and during this period about once every four or five months he would have a spell described by his wife as an unprovoked angry spell in which he would turn upon her with a "wild look" in his eye, take her by the throat, and choke her and hit her head against the nearest object. She had put up with these "because she loved him," but on the last occasion she had not been handy and he had taken their one-year-old child by the throat and began to hit his head and before she was able to release him, the baby was quite cyanotic. In this case, also, the electroencephalographic pattern was typical for an epileptic equivalent.

Many of the epileptic equivalents are not associated with such violence, and during the attack the individual may perform semiautomatic procedures as removing the clothing or carrying out some other common habitual act. The important diagnostic point in regard to these attacks is the amnesia which the patient has for the events during the seizure.

LESS COMMON TYPES OF EPILEPSY

Myoclonic. Myoclonic epilepsy is characterized by single jerks which may involve one limb or one side of the body.

Epilepsy with psychosis. Epilepsy and psychosis are rarely seen in combination. If such a combination does occur, the psychosis is usually of the manic-depressive type.

Affect Epilepsy. There has been considerable discussion as to how large a part psychogenic factors play in epilepsy. The opinion at the present time seems to be that, although psychogenic factors are not considered as the ultimate cause of epilepsy, they frequently act as a precipitating factor. The exact relationship between hysterical seizures and idiopathic epilepsy has never been entirely worked out. An excellent description of this relationship is given by Worster-Drought.¹⁰ The association of emotional factors and epileptic seizures was well seen in men who had their first seizures under conditions of stress during the war. There are many in whom emotional factors seem very definitely related to these seizures, as, for example, a boy of twenty who invariably had seizures in the phone booth after calling his girl friend for a date and having been turned down.

In Figure 1 is shown the relationship between organic and psychic factors in idiopathic epilepsy. At one side of the triangle are the purely psychogenic or hysterical elements. On the other side are the purely

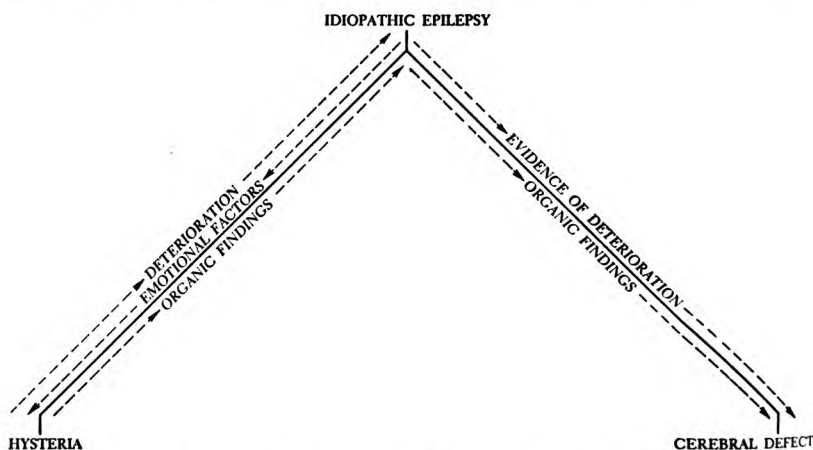


Figure 1. Diagram to show the reciprocal relationship between hysteria and epilepsy.

organic factors. As these two sides merge into the apex, there are elements of each entering into the formation of idiopathic epilepsy. Those patients showing the most marked physical stigmata of epilepsy and evidence of mental deterioration are most likely to show organic cerebral defects, frequently congenital. On the other side as it approaches a larger psychogenic origin there are no physical stigmata and no mental deterioration.

Jacksonian epilepsy. In this type of seizure, which is also known as focal epilepsy, the seizure starts in one part of the body, usually an extremity, and then spreads to other parts. It may be confined to one side of the body. The seizure very frequently will spread to the opposite side of the body. Consciousness is not usually lost unless this happens. The cerebral location of the irritating focus can frequently be determined by the group of muscles first affected by the seizures. For example, lesions in the frontal lobe are likely to disturb consciousness first and then spread to areas 8 and 6, causing rotary movements of the body before consciousness is lost and convulsions supervene. This type of lesion is exemplified by the following case:

CASE 58: Jacksonian Epilepsy Due to Scar

J. H., colored male, aged 44. His chief complaints were (1) epileptic seizures and (2) paralyzed left arm. History revealed that this patient had sustained an injury to his right temporal bone fourteen years ago when he was hit by a baseball bat. He was hospitalized at the city hospital and for a period of two weeks remained unconscious. When he regained consciousness, he discovered that he had a paralysis of the whole left side of his body. He was told that a plate had been put in his skull at the site of injury. Following this, he regained the use of his lower extremity but the upper extremity remained partly paralyzed. Soon after his discharge from the hospital, he began to have seizures about once a month which occurred only at night. These were characterized by an absence of an aura and the sensation of being grasped by the left arm, and then his whole body rotated backward and to the left. The attacks lasted about fifteen minutes, leaving the patient exhausted and sleepy. He returned to the city hospital where he was told to brace his body in a confined space to prevent rotation, but was given no medication. These attacks have continued until the present time. Physical examination showed a well-developed, well-nourished, colored male of about 44 years. On walking, he dragged his left leg and his left arm did not swing normally. There was a large depression of the right temple area with a large white scar in the center.

There was slight atrophy of the left upper and lower extremities with exaggerated reflexes of the entire left side. There was poor coordination on the left and some difficulty in movement, although movement was possible. His blood Kahn was positive. Spinal-fluid examination was entirely negative. The neurosurgeon felt, because of the age of the lesion and its extent, that surgical treatment at the present time was not indicated. The syphilologist recommended routine antiluetic therapy.

Status epilepticus. Status epilepticus is a condition in which the patient has a series of convulsions very close together. He usually does not regain consciousness between the attacks and unless the attacks can be terminated, the seizure is likely to terminate fatally.

DIAGNOSIS

The diagnosis of epilepsy is not always easy. In the typical grand mal attack, if it is observed by one familiar with its characteristics, the diagnosis is not usually difficult. It would, of course, be necessary to rule out symptomatic epilepsy. Petit mal is frequently confused with other conditions or the seizure may be missed even by the patient himself for a long period of time, if the attacks are short in duration and occur infrequently. The epileptic furor is not likely to be missed if the condition is borne in mind. It must be remembered that the clinical picture of epilepsy is protean in its manifestations and that in the same patient all varieties of the condition may be seen. Although it is customary for the patient to have the same type of aura with each seizure, this may also change and any combination or varieties of seizures may be present in the same patient at different times. If this condition is not kept in mind, less obvious cases may be missed at first. Some of the difficulties encountered in the diagnosis of epilepsy may be seen in the following case:

CASE 59: *Epilepsy: Petit Mal With Occasional Grand Mal Seizures*

R. G., age 18. This patient was first seen in the Out-Patient Department about two years ago at which time he complained of a marked sudden gain in weight. He was 16 years of age and weighed about 210 pounds, having gained 50 pounds in the previous six months. He also related a story of increasing irritability, difficulty of adjustment at home, severe headaches, and occasional attacks of vertigo. He had several times momentarily blacked out. Emphasis was placed upon the weight, and the original tentative diagnosis was Frohlich's Syndrome. Except for his marked obesity, physical exam-

ination at this time was essentially negative except for an elevation of the blood pressure — systolic of 180 and diastolic around 100. He was placed upon a reducing diet and no medication was given. He returned at intervals for revisits and although he had lost some weight, he continued to complain of irritability, headaches, and occasional attacks of vertigo. He described his attacks as occurring in the following sequence: irritability, vertigo, momentary blackout, followed by a headache which would last for several hours.

He was readmitted to the hospital some months later in a stupor and although no definite history could be elicited, his mother thought that he had swallowed an overdose of a sedative, which he subsequently denied. After admission to the hospital, however, he remained in a stuporous condition for a period of almost 36 hours, during which he would respond to questions, but showed no interest in the environment and had no complaints when questioned except of headache. He remained in the hospital for a short period and was seen by a psychiatrist whose impression was that of depression, and he was advised to return to the Out-Patient Department for psychotherapy.

After being discharged from the hospital, he did not return to the Out-Patient Department as requested, but instead was not heard from for a period of several months, when he was readmitted to the hospital again with the history of having taken an overdose of sleeping pills, which, however, he again denied.

After admission to the hospital he again remained stuporous, responding only to strong stimuli for a period of about 36 hours. On the second day after admission he was interviewed by a psychiatrist who elicited the following history: "The patient has seldom been able to make any friends. He has been solitary for a large part of life, never enjoyed school, and never did very well in his studies. He was not particularly happy at home which was disrupted by the fact that his mother worked long hours and would leave home early in the morning and would not return until late in the afternoon. He got along very poorly with his sister with whom he would constantly argue. The father and mother had separated many years ago and he had little knowledge of his father. About a year before, he had left school and taken a job in a butcher shop. He apparently did well as a butcher and, because of the man-power shortage, was able to demand a fairly high salary. He is unable to account for a large part of the money which he earned, and for which he has nothing to show. He kept the money he earned and turned nothing over to his mother. He became very intimate with the boss in the butcher shop, who was a woman, and on several occasions would spend the night at

her home. Aside from this association, he seldom went out with anyone else and had no close friends. He would occasionally go to the movies alone, and his only other recreation was in taking long walks usually at night. He stated that frequently while walking along the street he would hear his name called and would turn and see no one who could have called his name. In addition to his name, he had occasionally heard other voices calling him by a variety of derogatory names, some of which implied that he was a homosexual. In addition to the name calling, he stated that on several occasions he had had a vision of his mother who appeared to be talking to him although he could not understand what she was saying. He stated, in fact, that he had had one such vision since he had been in the hospital." With this evidence of a schizoid personality he was treated with subshock insulin therapy under which he showed considerable improvement and he began to mix with other patients on the ward and began to show an interest in the ward activities, on many occasions helping with the cleaning on the ward, which he had not done on his previous admissions. On one occasion after he had been on subshock insulin therapy about one month, he had a major convulsion 30 minutes after he had received his dose of insulin which was interpreted at the time as a hypoglycemic convulsion. After the seizure, however, he complained of a headache similar to those which he had had associated with his blackouts. Examination at this time, which included a complete neurological study, showed no evidence of abnormality.

After several months he was readmitted during the night with the following history which was given by his mother. "The family had gone to bed between 11:00 and 12:00 that night and everyone had apparently gone to sleep, when between 2:30 and 3:00 the mother was awakened by hearing the patient thrashing around in his bed. She went to his room where she found him having a convulsion, during which he bit his tongue and produced a slight laceration of his lip. She stated that she had never seen him have any similar attacks." He again remained stuporous for about 24 hours and the mother again discovered that a large amount of sedative tablets were missing. On this admission an electroencephalogram was done which was reported as follows: "8 leads electroencephalogram with monopolar and bipolar recording: Electrodes are placed along symmetrical parasagittal lines over each cerebral hemisphere in the frontal, temporal, parietal, and occipital regions. Medium to high voltage, slightly irregular activity 9-10 per second is recorded on both sides. The wave patterns are fairly well organized. The alpha activity, when present, is well outlined. There is a general tendency of the

activity to be spiky, particularly over the frontal areas. Occasional slow waves are detected from the parietal and occipital areas. Marked slowing and big build-up with hyperventilation. *Impression* — Diffusely abnormal electroencephalogram."

The patient has been seen at intervals since then, and he is now having minor seizures, approximately once every two weeks. The last two seizures have been characterized by a cataplectic state in which he has fallen to the ground, without, however, injuring himself, has lost consciousness for a short period, has then been able to resume his activities although he does have a headache following.

The electroencephalogram. A great advance in the diagnosis of epilepsy was made when the electroencephalogram was discovered. Caton, an Englishman, studied evidence of electrical activity in the brain as early as 1874. It remained, however, for Hans Berger, in 1902, to actually record the brain waves of animals and to realize their importance to neurophysiology. From this time until 1933, Berger carried on his investigation and put the electroencephalogram on a firm clinical foundation. The full value of the electroencephalogram is probably not yet fully realized. At the present time it has its greatest use in the diagnosis of epilepsy and there is a typical brain wave pattern for each of the three types. (See Fig. 2.)

1. Petit mal seizure — approximately 3 per second waves with a spike and a slow wave alternating.

2. Grand mal seizure — tonic phase characterized by pure fast discharge (15-40 per second).

3. Psychomotor seizure — flat topped 4 per second waves mixed with high voltage 6 per second waves.

It is important to remember that abnormal brain waves occur in other conditions than epilepsy and epileptic brain waves of a rather typical appearance may be seen in other cerebral lesions without any clinical evidence of epilepsy. As pointed out above, abnormal electroencephalographic patterns may be seen in a high percentage of the relatives of those with clinical epilepsy.

Spinal fluid. Spinal-fluid examination is usually normal, although about 20 per cent of the patients show a moderate elevation of the spinal-fluid pressure and a slight increase in protein.

X ray. X-ray examination is likely to show very little in the idiopathic case. In those cases characterized by congenital defects, dilation of the ventricles and other characteristic changes may be seen.

Although many other conditions are occasionally confused with

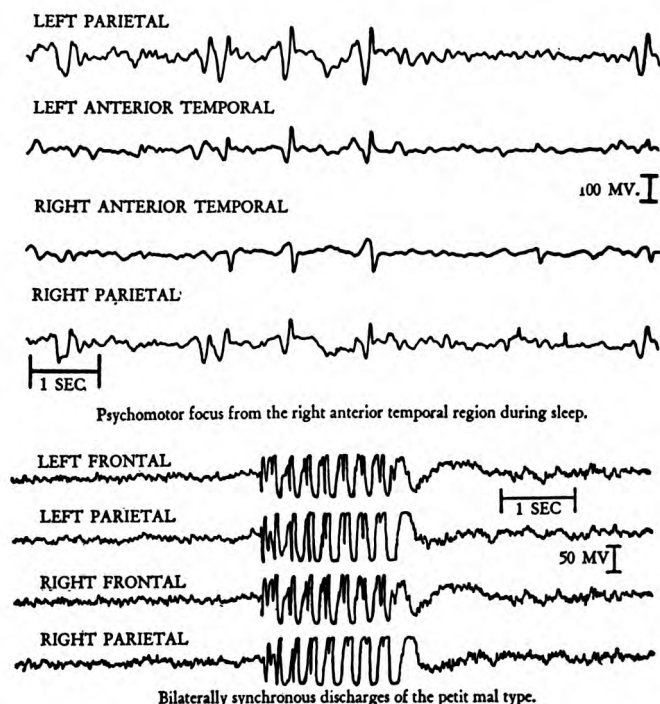


Figure 2. Typical Electroencephalograms (Spike and Dome).

epilepsy, the most difficult differential diagnosis to make is between major hysterical convulsive seizures and grand mal. There are a number of points which help in this differential diagnosis as indicated in the accompanying table. (See table on page 515.)

PROGNOSIS

Suicide in Epilepsy

There has been an opinion prevalent in some quarters that suicide is unusual in epilepsy; however, Prudhomme,¹¹ reporting on figures from the Craig colony gave a suicide rate of 22.8 per 100,000; whereas, the average suicide rate for the country as a whole was 9.7 per 100,000. If corrected to take out the group under 15 years of age (30 per cent) and those under 15 at the time of death (18 per cent), this 48 per cent could be considered not likely to commit suicide. The corrected figure

would be 1 suicide for each 2189 patients a year or a rate of 45.6 per 100,000. This figure is for institutionalized and supposedly deteriorated patients who would not be expected to commit suicide. There were 67 known suicides in 75,000 epileptics, 30 of which were due to phenobarbital. Many emotionally unstable people make suicide attempts when the condition is first diagnosed.

Differential Diagnosis of Hysterical and Epileptic Seizures

	<i>Hysteria</i>	<i>Epilepsy</i>
<i>Amnesia</i>	Frequently absent	Always present
<i>Consciousness</i>	Frequently retained	Lost
<i>Eyes</i>	Tightly closed — difficult to open, rolled up	Open — fixed and staring
<i>Pupillary light reflex</i>	Rarely lost	Lost
<i>Anesthesia of cornea</i>	Present	Present
<i>Babinski</i>	Not present	Present
<i>Blood count</i>	Unchanged	May be changed
<i>Voice change</i>	Varies	Plateau voice
<i>Injury</i>	Absent	Present
<i>Incontinence</i>	Absent	Present
<i>"Belle indifference"</i>	Present	Absent
<i>Audience</i>	Essential	Not essential
<i>Postseizure stupor</i>	Absent	Present
<i>Pallor</i>	Absent	Present
<i>Cyanosis</i>	Slight, if present	Marked
<i>Electroencephalogram</i>	Normal pattern	Typical pattern

Mental Deterioration

No mental abnormality is constantly associated with epilepsy. Many epileptic patients do not exhibit any mental deterioration. Mental deficiency is frequently present and very frequently epileptic children are emotionally unstable, difficult to control, and show little interest in school. The cause of the mental deterioration frequently associated with epilepsy is not known. It seems unlikely that this is related to the frequency or severity of convulsions because many patients with severe convulsions show no mental deterioration. In the minds of many of those who have studied the subject, the possibility that bromides have contributed to this mental deterioration seems not unlikely. However, as Brain points out, it is possible that both the convulsions and the associated dementia are the expression of some unknown physiological abnormality.

What sometimes appears at first glance to be mental deterioration

is a confused state which may persist for quite long periods, even days following a seizure. This confusion following seizures is of special importance because it may lead to errors in diagnosis.

CASE 60: *Epilepsy With Prolonged Postepileptic Confused State*

B. B., white female, age 34, was referred for a physical checkup in regard to her ability to work. Her family history was essentially negative. There was no history of convulsive disorders. Past history was essentially negative except for the usual childhood diseases. Her present illness dated from about three months prior to examination when she had a convulsion. Two months later she experienced a second convulsion. Both occurred while she was at work, and the patient was unable to give any description of them from her own knowledge. Examination of the systems was essentially negative except that it was noted that she was easily irritated and regarded herself as a "very nervous individual."

Physical examination revealed an obese, mentally retarded, somewhat apprehensive white female. The remainder of the examination was essentially negative except for a scar 5 cm. long over the left upper orbital region.

Neurological examination revealed no gross evidence of abnormality, although this consultant elicited the fact that she had had frequent convulsions as a child. Diagnosis was deferred pending psychiatric consultation. The psychiatric consultant reported as follows: "For a woman who has been subjected to the amount of education she described (second year of college) she is extremely vague in the information she gave concerning herself. During the entire interview, she never at any time volunteered any spontaneous remarks or information about her illness or her symptoms. From a psychiatric point of view, I can only remark that this woman impresses me as being mentally retarded, and I believe that this condition has been in evidence all her life."

Laboratory studies were essentially negative.

Follow-up through the medical social service elicited the following additional information: "On the first contact she seemed dull and confused, with no clear idea of the convulsions and a general air of apprehension about her visits to the clinic." No information of value was elicited and the social worker merely passed on to the patient the doctor's orders for return visits, and tests. The patient was seen and questioned again about her seizures or "spells" as she called them. Her answers were much more directly given and she seemed much less confused than formerly. Information was as follows: When the patient was three or four years old, she stepped

on a burning log which had fallen out of the fireplace to the floor. She remembers having to learn to walk again and she was sure that the family doctor gave her some liquid medicine. She was unable to go to school until she was about eight because of these seizures. From then on, however, she was very well, finished high school and two years of college and taught school near her home. Finally, she passed the Civil Service Examinations for junior clerk. About three months prior to being seen she had her first attack. She stated that she simply felt faint as she does before her menstrual periods at times. She does not remember falling and striking herself (has scar on her forehead as a result of one attack) and denies incontinence. She feels that the recent attacks were closer together but did not last so long. (This last statement was confirmed by the nurse in her office who had told me of about five attacks of which the first was 30 minutes or so in duration, while the last two, occurring on the same date, were only a few minutes.)

MARRIAGE

It has been the custom for many years to advise against the marriage of epileptic patients, but since the introduction of electroencephalographic studies, it is likely that at the present time, anyone familiar with the subject would not advise against the marriage of epileptics unless both partners to the marriage have positive evidence of epilepsy in their electroencephalograms. (See "Heredity," above.)

WORK

Many epileptic patients have their seizures at night; consequently, they are not likely to interfere with their daily occupation, or even if they do have an infrequent attack during the working hours, it is not likely to cause too much disruption in the daily routine. A study by Brain¹² showed that, in 42 per cent of a series, seizures occurred only during the day, and 24 per cent had seizures only at night. The remainder had seizures both day and night. It is, however, inadvisable for epileptics to be employed in a place where they are around machinery or dangerous heights because during the seizure the patient may fall and be seriously injured. The best answer to the question of the epileptics's ability to hold a job is the report of the American Epilepsy League¹³ which covered a nine-month period and dealt with a group of slightly more than 100 persons in the Boston area who previously had not been self-supporting. Eighty per cent of these persons were found to be employable, and they held jobs bringing them

an aggregate annual income of \$120,000. Epileptics, like others, have to be hired on the basis of what they can do. The ability of the epileptic to work may be confusing to those who are aware that the armed forces turned down all epileptics. This, however, did not indicate that in the opinion of the Services these men were unable to perform useful work. It was, however, necessary in the Service to have men fully fit for every duty. Therefore, any man who could not be considered 100 per cent effective was rejected by the Army and the Navy. In civil employment, however, these men would be able to carry out a full day of work.

SCHOOL

The question of school for the epileptic child often comes up. While the mind is busy the epileptic seizure is much less likely to occur. For this reason epileptic children will probably have few seizures during the course of the school day, and even though the child does have an occasional seizure in school, it is certainly desirable to have him continue his normal activity if this is at all possible. School authorities will occasionally be found who object to the presence of the child in the school because of the possibility of injury to himself and the effect of the seizures on the other children. Such school authorities are in need of education, and the best method of handling the epileptic child in such instances is the education of the school authorities in epilepsy. It creates a very bad impression on the child if he must be set aside from others, and it adds emphasis to the feeling of inferiority which he already has, if he feels that he may not associate with the other children. A simple explanation to the other children of the nature of the attacks will quickly remove any concern which is aroused in them by seeing the seizures in one of their schoolmates.

INSTITUTIONAL CARE

The question as to whether or not institutional care is necessary for the epileptic will depend on a number of factors, the first and most important of these being the situation at home. In most cases, of course, the epileptic patient will get better care at home than he would in any institution. If, however, the parents are not sufficiently intelligent, or are fearful of the disease, or of the patient having the seizure, or if there are other detrimental factors in the environment, at least temporary care away from home would probably be desirable. During

this period the family would have a chance to readjust itself and the patient could perhaps later spend a good deal of time at home. If the individual is markedly deteriorated, and is having frequent seizures, institutional care may be definitely indicated.

TREATMENT

The treatment of epilepsy should always be highly individualized.

In *symptomatic epilepsy* the etiological factors should always be sought and, if possible, eliminated.

In *idiopathic epilepsy* treatment is divided into four types:

1. Drug therapy,
2. Diet therapy,
3. Dehydration,
4. Psychotherapy.

Drug therapy. The treatment of epilepsy by drugs has the widest application because of the ease of their administration and control. Bromides were formerly used almost exclusively, but because of the frequency of bromidism and the discovery of the newer more effective drugs, they are seldom used at the present time. They have been largely replaced by phenobarbital. This drug is better tolerated than bromides, has a wider margin of safety, and is equally, if not more, effective in the control of convulsions. The usual dose of phenobarbital is from $\frac{1}{2}$ to $1\frac{1}{2}$ grains three times a day. An anticonvulsant without sedative effect, *sodium diphenyl hydantoinate (Dilantin)*, promises to be more effective than either of the above-named drugs for grand mal attacks. It is given in doses from .2 to .6 grams daily and is relatively safe, but the patient should be watched for gingival hypertrophy which not infrequently results from its use. *Tridione* (3,4,4-trimethyloxazolidine-2, e-dione, Abbot) is a new synthetic anticonvulsant drug which has been demonstrated clinically to have a definite inhibiting effect on petit mal, myoclonic, and akinetic seizures in epilepsy. The dosage of tridione must be determined by the response in the patient. In general it varies from 1 to 2 grams per day for petit mal cases. This is best given in divided doses. The dose should be decreased if drowsiness occurs. If other toxic effects appear (skin rash, gastric irritation, or a "glare" phenomenon), the dose should be reduced. If these effects persist, the drug should be withdrawn. Frequent white blood counts should be made while the drug is being used because of the tendency to produce agranulocytosis.

Diet therapy. The use of the ketogenic diet (q.v.) is based upon the fact that a certain degree of acidosis will reduce the tendency to

convulsions. The diet is, however, difficult to control and expensive. It has its greatest value in petit mal in children.

Dehydration therapy. This consists of markedly reducing the fluid intake and seems to have been effective in some cases.

In general, it may be stated, following the classification of Lennox, that Jacksonian and localized convulsions are best treated by surgical removal of the focus if this is possible. If this is not possible, they should be treated with dilantin or phenobarbital. Grand mal and psychomotor seizures are best treated with dilantin or phenobarbital. Petit mal, myoclonic jerks, and akinetic seizures are best treated with tridione or the ketogenic diet.

Psychotherapy. In spite of the contention of some authors that there is no such condition as affect epilepsy, there is little doubt in our minds that emotional factors play a large part, if not in the causation, at least in the precipitation of epileptic seizures. For this reason, a personality inventory of the epileptic patient should never be neglected, proper mental attitudes should be promoted, and emotional tension should be corrected.

TREATMENT OF THE SEIZURE

The seizure itself requires no particular treatment except the protection of the patient from injuring himself. The best means of doing this is to provide a mouth gag which is inserted in the mouth at the time he opens his jaws in the beginning of the clonic convulsion. No effort should be made to force the jaws apart during a clonic seizure since it can do no good and may result in breaking the teeth.

FOOTNOTES

1. Stanley Cobb, *Borderlands of Psychiatry* (Cambridge, Mass.: Harvard University Press, 1944), p. 106.
2. J. W. Lennox, *Science and Seizures* (New York: Harper & Brothers, 1941), p. 19.
3. Russell Brain, *Diseases of the Nervous System* (New York: Oxford University Press, 1945), p. 852.
4. Lennox, *op. cit.*, pp. 15-16.
5. *Ibid.*, p. 37.
6. Brain, *op. cit.*, p. 855.
7. *Ibid.*, p. 857.
8. W. R. Gower, *The Borderland of Epilepsy* (Philadelphia: Blakiston & Co., 1907), p. 897.
9. F. A. Gibbs and E. L. Gibbs, *Atlas of Electroencephalography* (Cambridge, Mass.: Addison-Wesley Press, Inc., 1945).
10. C. Worster-Drought, "Hystero-Epilepsy," *Journal of Medical Psychology*, 14:50-82, 1934.

11. C. Prudhomme, "Epilepsy and Suicide," *Journal of Nervous & Mental Diseases*, 94:722-731, December, 1941.
12. Brain, *op. cit.*, p. 862.
13. Herbert Yahraes, *Epilepsy, The Ghost is Out of the Closet*, American Epilepsy League, Public Affairs Committee Pamphlet 98, 1944.

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MENTAL DEFICIENCY

DEFINITION

The term "feeble-minded," is used generically to include all degrees of mental defect due to arrested or imperfect mental development as a result of which the person so afflicted is incapable of competing on equal terms with his normal fellows or of managing himself or his affairs with ordinary prudence [American Association on Mental Deficiency].

Mental defectives are subnormal. They have never attained full mental growth and in this respect differ from those affected by a neurosis or a psychosis inasmuch as those so affected have once reached normalcy and then deviated from it. In every case of mental deficiency there is intellectual subnormality, i.e., the person is substantially backward in intelligence. In England¹ the standard for certifying children for special schools is that they be backward by three tenths of their age, i.e., when ten years of age their responses are equal to or below those of a child of seven. Adults are considered subnormal chiefly on grounds of socioeconomic incompetency, but such adults seldom surpass the mental levels of ten- or eleven-year-old normal children.

Explanation of the Definition

Mental deficiency and feeble-mindedness. Frequently an attempt is made to distinguish between mental deficiency and feeble-mindedness. Such a distinction has no practical value and for many people, the terms are synonymous. When a distinction is made, mental deficiency is the broader term. It includes, besides the technically feeble-minded, the innumerable subnormals that populate the vast no man's land between complete normalcy and high-grade feeble-mindedness. If there is any accepted dividing line between these two classes, it is the fact of social competency or the ability to maintain oneself as an efficient member of the group. There is no sharp or clear-cut division between the socially competent or incompetent, but the two groups are largely distinguishable. *Mental deficiency is the term applied to all those, who, because of diminished or subnormal intellect, are to a*

greater or lesser degree incapable of maintaining their status in the group.

The term "feeble-mindedness" is used in a more limited sense and as used in this country at the present time contains four elements:

- a) Mental limitation or deficiency,
- b) Cerebral defect,
- c) Inherited or acquired in early life,
- d) Termination in social and economic incompetence.

ETIOLOGY

It should be realized that feeble-mindedness is not a simple biological trait that appears uniformly and owes its existence to a few easily recognized, specific causes. As a matter of fact, it is a condition having a wide range of physical, emotional, and volitional characteristics, and due to obscure, highly variable, and often multiple causes. Even the pathological brain condition basic to the defect is not uniform and is seldom clearly understood. It can be said that feeble-minded people differ from each other as much as if not more than normals differ among themselves. No two feeble-minded are alike except in the vague, generic characteristic of mental deficiency.

Feeble-mindedness is due either to heredity, environment, or to a combination of both causes.

1. *Heredity.* Former claims of the hereditary nature of feeble-mindedness have been modified by recent scientific findings.

a) Landman,² in his work on *Human Sterilization*, after reviewing a great number of studies on the inheritance of mental deficiency, felt that heredity was an important factor but admits that little or nothing is known definitely and that studies made on the problem were of little value.

b) The Committee of the American Neurological Association³ reports in its work on *Eugenical Sterilization* that very little scientific work has been done on the heredity of mental deficiency and, presumably due to the lack of reliable data, does not commit itself.

c) Davies,⁴ in his *Social Control of the Mentally Deficient*, after reviewing a number of significant studies on the heredity of feeble-mindedness, felt that the only thing about which we can be certain is our uncertainty, but offers the tentative estimate that half or less of the feeble-minded in institutions and even less of noninstitutional cases are hereditary.

d) Hauber,⁵ in his *Problems of Mental Deficiency*, summarizes pre-

vious studies and feels that the average opinion would be that between 25 and 33 per cent of mental defect is inherited.

Clearly, it is impossible to know with any degree of certainty to what an extent heredity operates as a cause of feeble-mindedness. Most feeble-minded children are produced by apparently normal parents. If they are carriers, defective heredity may be responsible in some of these cases.

2. *Environmental factors.* The environmental factors producing the organic brain damage may be the result of (a) intrauterine developmental defects or (b) early postnatal trauma or disease. Of the more common types of feeble-mindedness, those associated with microcephalus, macrocephalus, hydrocephalus, and mongolism, are due to intrauterine failure of development. Traumatic, meningitic, paralytic, choreic, epileptic, and endocrine types, such as cretinism, are probably due to postnatal influences. Hauber indicates that many of these environmental factors may operate due to some hereditary defects. It is never possible to be certain, but he considers heredity to be the principal cause.

INCIDENCE

After reviewing studies made in England and Wales, Tredgold⁶ thinks that for those countries mental defectives constitute not less than 1 per cent of the population. S. P. Davies⁷ estimates the number of feeble-minded in this country to be less than 1,000,000. Bernstein,⁸ after giving estimates of principal authorities on this subject, deduces that it may be conservatively estimated that mental defectives constitute about four tenths of 1 per cent of the population, or not more than 500,000, of whom one half are children. About one half of feeble-minded children die before reaching adulthood. The higher-grade defectives far outnumber the lower grade. Two thirds of the feeble-minded belong to the moron class, about 15 to 18 per cent are imbeciles, and the rest are idiots. The opinion that the number of feeble-minded is on the increase has been shown to be without foundation.

CLASSIFICATION OF FEEBLE-MINDEDNESS

The psychological classification of mental defect is based on standardized tests of attention, understanding, performance, memory, planning, association, and so forth. In the intelligence tests standardized by Professor Terman⁹ of Stanford University there are six questions

for each year of age, graded in difficulty, each year being adjusted to the normal development of that period. To find the mental age by this method, the highest year is taken in which the individual can answer all the questions or perform the various tasks. This is spoken of as the "basal year." To the basal year are added any questions answered in the higher years, each being given two months' credit; for example, if a child should answer all the questions up to, and including, the fifth year (Basal Year), four questions from the sixth year, two from the seventh year, and two from the eighth year, this would give him a mental age of five plus eight months for the sixth year, or a total of five years plus sixteen months or six years and four months.

For greater simplicity and easier grading of mentality, the intelligence is usually expressed as a quotient, better known as the I.Q.

$$\text{I.Q.} = \frac{\text{Mental age (in terms of months)}}{\text{Chronological age (in terms of months)}}$$

The standard intelligence quotients are:

Idiot	0 to 20
Imbecile	20 to 50
Moron	50 to 70
Borderline	70 to 80
Low Normal	80 to 90
Normal	90 to 110

The following definitions based on mental age are those usually given for adults:

Idiot: One whose mental age is less than three years.

Imbecile: One whose mental age is between four and seven years.

Moron: One whose mental age is between seven and twelve years.

GENERAL CHARACTERISTICS OF FEEBLE-MINDEDNESS

1. *Biological*. There always exists in cases of feeble-mindedness a basic defect or organic deficiency in the brain. Besides this, there is no other biological defect common to all the feeble-minded. Some feeble-minded persons have no bodily defect other than cerebral deficiency. But most of them possess some additional defect of anatomical structure or disturbance of physiological function. Some writers have called these defects the "stigmata of degeneracy." The term is objectionable and is not widely used. There are no "stigmata of de-

generacy" in the sense of essential, ever present, noncerebral physical defects to be found among the feeble-minded, and even if there were, "stigmata" would be a poor word.

Biological defects are far more common among the feeble-minded than among normal people. Cerebral deficiency or defect, hereditary or acquired, severe enough to cause substantial mental deficiency, is often associated with other physical deformities and anomalies as well.

2. *Emotional.* There are no fixed emotional characteristics of feeble-minded people. Mental defectives are classically of two types, the *unstable* and the *apathetic*. Great numbers of the feeble-minded do not fall into either of these two classes.

3. *Mental and educational characteristics.* As a result of the lowered intellectual condition of the feeble-minded, there is a general lessening of all the functions of the mind. Judgment, reasoning, memory, understanding, and discrimination are all impaired to a greater or lesser degree. The more profound the deficiency the more the powers of the mind will be affected. More frequently there is a fairly uniform retardation of all abilities, but there are exceptions to this tendency. In some cases of feeble-mindedness, retardation of one power may be accompanied by ordinary and even extraordinary development along other lines. The most remarkable examples of this latter condition are found in the rare and occasional "idiot savants" (Tredgold).¹⁰

The ability of feeble-minded children to profit by ordinary educational facilities is correspondingly limited. Children suffering from other handicaps may also have a defective capacity for scholastic performance.

4. *Character.* By character is meant life — emotional, mental, and volitional — dominated by the will. It is fundamentally a question of conscious self-control exercised by will power. Defective brain leads to defective intellect. Defective intellect results in enfeeblement of will and character. The general trend is, of course, toward diminished or lessened control and to characters of weaker and less developed texture. But feeble-minded persons have character, good or bad. Even brief familiarity with these people reveals the fact that there are good and bad feeble-minded just as there are two classes of normals. Mentally deficient people react to conditions of good or bad home training, to good or bad school, community, and religious influences just as other people do. Feeble-minded children who have been well-trained develop into trustworthy and reliable people. The opposite is likewise true.

5. *Moral characteristics.* The feeble-minded possess moral responsibility proportionate to their intellectual level. There are some low-grade defectives in whom intellect is so poorly developed that there can be no question of personal responsibility. The higher grade of feeble-minded are able to distinguish between right and wrong and can be considered at least partially responsible for their acts. The old classification of "moral imbecility" in the sense of mental defectives who have diminished intellect and no moral sense is not justified. There have been found no persons of even diminished intellect who do not possess corresponding moral sense.

INDIVIDUAL TYPES OF FEEBLE-MINDEDNESS

Generic feeble-mindedness has already been defined and explained. It is a condition of social incompetency due to diminished intelligence caused by cerebral defects, inherited or acquired in early life. There are three degrees of feeble-mindedness:

- a) Idiots, b) Imbeciles, c) Morons.

Idiots

CHARACTERISTICS

1. *Physiological.* The organic cerebral defect found in all degrees of feeble-mindedness reaches its maximum in idiots. Many other serious defects of almost any part of the body may also be present. Some of these are characteristic of definite types of idiocy but are accidental to the generic condition. Profound cerebral defect is essential.

2. *Psychological.* Idiots are seriously handicapped. They cannot read or write, know only a few articulate words, if any, cannot reason, and have no moral responsibility.

3. *Educational.* Idiots have a mental age of two or three years or less. They are incapable of any education. They can at times be taught to do simple things, but many are incapable of washing, clothing, or feeding themselves, and cannot be taught to do so.

4. *Sociological.* They are best described in the words of the "Mentally Deficient Act," passed by Great Britain in 1927. Idiots are "persons in whose case exists mental defectiveness of such a degree that they are unable to guard themselves against common physical dangers." They are completely dependent economically.

CASE 61: *Idiot*

A second child was born to a young couple who belonged to one

of the better families in town. From the very beginning, the mother thought she noticed a slightly peculiar set of features and a lack of muscular co-ordination in her child, but she said nothing. The infant for a while gave no other indications of subnormalcy until the time of teething arrived. This was considerably delayed as were also the development of walking and talking. These abilities were finally acquired but only imperfectly. The child, now seven years of age, walks but awkwardly. He is more than ordinarily clumsy. His ability to talk is definitely below that of a seven year old. He cannot yet form sentences but speaks only in monosyllabic utterances, such as "man," "cat," "house." There is defective sphincter control. In general the biological development has been retarded.

Imbeciles

CHARACTERISTICS

1. *Physiological.* Their condition is not so unfortunate as that of idiots but there is serious cerebral defect, though not so profound or complete. In other details of physical condition, they vary considerably. Some are entirely free from all organic defect other than cerebral deficiency, but most of them possess deformities of body and other anomalous conditions.

2. *Psychological.* They are superior to the idiot class. They have some mentality but not much. Few of them may be able to read or write but, if so, only imperfectly. They may know some words but cannot carry on a conversation. They possess limited understanding and have no moral responsibility.

3. *Educational.* Imbeciles have a mental age of between three and seven years and an intelligence quotient of between twenty and fifty. Wallin, after long experience, states that with, at most, one or two exceptions, he never knew imbeciles who could do first grade work, even after six or seven years of schooling. Fifteen per cent of ordinary progress was their best achievement. This indicates that some minimal education is possible to the higher class of imbeciles.

4. *Sociological.* The state of imbeciles is well expressed by the "Mentally Deficient Act." They are "persons in whose case there exists mental defectiveness which, though not amounting to idiocy, is yet so pronounced that they are incapable of managing themselves or their affairs or, in the case of children, of being taught to do so." They cannot support themselves and are 100 per cent dependent from the social point of view.

Morons

CHARACTERISTICS

1. *Physiological.* Morons suffer from some degree of cerebral defect. Tredgold says that it was his experience that most moronic children have abnormal craniums. In a degree, less universal and less marked, they also exhibit many of the physical deformities found in other types of feeble-minded. But many morons, especially of the higher type, are normal or nearly so in this regard.

2. *Psychological.* They are characterized by a general lack of intelligence. They have a diminished capacity of understanding, and all the abilities that are dependent upon or manifestations of this fundamental power. They can think and reason, but not too well. Their ability to compare, discriminate, appreciate, concentrate, and remember is diminished.

3. *Educational.* They are, of course, defective, but much more promising than the lower degrees. They possess a mental age of from seven to twelve and an intelligence quotient of seventy or less. The low-class morons respond to educational technique better than high-grade imbeciles. Morons of better intelligence with difficulty reach the third or fourth grade but are too defective to profit by ordinary grade school education. They require special training. Many high-grade morons profit greatly by specialized education that develops social qualities necessary for life in the community. Modern well-organized institutions for the feeble-minded are doing good work in this regard.

4. *Sociological.* Morons are of two different classes. Those who are correctly classified as feeble-minded are the people of defective intelligence who cannot support themselves or their dependents nor maintain normal social status. They are a burden to the community. Many high-grade morons can, by skillful training especially adapted to their state, be made economically independent. Some may and do marry and have normal children. These cannot and should not be classified as feeble-minded.

CASE 62: *Moron*

Alex was well known at the ball park where he sold Coca Cola at all the football and baseball games. He could not pronounce the name of the commodity he distributed correctly because of a speech defect, but everybody liked him, and he was well patronized. He wore glasses and lumbered along in a peculiar loping fashion.

Alex had a relatively brief but difficult time in the public school system. He failed in every grade he entered but as a reward for his patience, and because of the eagerness of his teachers to get rid of him, he finally reached the sixth grade, but could not go any higher. He had been tested frequently, and the highest I.Q. he ever attained was 68. At a meeting of the Public School Child Guidance Clinic, where his case was discussed, it was recommended that he be withdrawn from the school system and put to work on a farm at doing some simple tasks that were compatible with his diminished intelligence. The rural experiment did not work. He could not get used to the country. He is doing very well as a vendor of Coca Cola at the park's concessions.

Borderline Mental Defectives

There is a large group of individuals with subnormal mentalities who, though not feeble-minded in a technical sense, are nevertheless socially incompetent. A good percentage of hobos, prostitutes, and other social misfits may be drawn from this class.

CASE 63: *Borderline Mental Defective*

J. O. was a well-known character of a small town, in a Western community. He died at the age of 46. Though penniless and reduced to extreme poverty at the time of his death, he had always managed to support himself by doing odd jobs around the neighborhood such as chopping wood, mowing lawns, running errands, and other simple chores. He could scarcely read or write, having had only a few years of schooling. He stammered and his speech was defective. He dressed poorly, but was always clean. He never married and lived alone in a little cabin. He had a peculiar characteristic walk. No one knew his origin but he lived in the community over twenty years. He was well behaved, extremely simple, and childish, the object of fear to some children, the butt of ridicule to others. He was accepted by the group in which he lived and led a life of marginal usefulness.

MONGOLIAN IDIOCY

Definition

Mongolian idiocy is a type of congenital amentia or feeble-mindedness characterized by quite distinct physical traits and by psychic abilities for the most part within the imbecilic range of intelligence.

History

In 1866, John Langdon Down first used the term "Mongolian Idiot" to describe this syndrome. He attempted to establish an eth-

nological basis for mental deficiencies, and thus to indicate their causes. He endeavored to connect certain types of amentia causally with Malayan, Indian, Negroid, and Mongolian appearance, blood, and descent. Those whom he called Mongolian Idiots, he claimed, had the traits of the Mongolian race, and were descended from it. What J. Langdon Down did to explain the etiology of Mongolism is practically the same as that which psychiatrists do today when they attribute manic-depressive psychoses to a pyknic body build and schizophrenia to a leptic physical structure.

Later investigations on his part, and on that of others, however, rendered it impossible to find a sufficient number of idiots who could justly be placed under the various other ethnic groups. Many able psychiatrists deny the very existence of the syndrome which is supposed to portray the Mongolian Idiot. They point out that the numerous physical and psychic characteristics of Mongolian idiocy may be found separately and singly in perfectly normal individuals, as well as in practically all other types of mental disorders.

An ethnic classification has long since been abandoned, but the term "Mongolism" is still applied to an important clinical variety of aments owing to a certain resemblance they bear to members of the Mongolian race. Whilst a change is now undesirable, one cannot but regard the name as somewhat unfortunate, because, although it is true that sufferers from mongolism do present a certain superficial resemblance to racial Mongols, they present many other anomalies which are not found in normal members of this race, and which are definitely pathological.¹¹

It is also apparent that the term "Mongolian Idiot" is not too happily chosen since Mongols as a class are imbeciles rather than idiots.

Though John Langdon Down established the classification which is called Mongolian Idiocy in 1866 and enumerated its salient symptoms, it was not until 1876 that the first thorough study on it was published. In that year Arthur Mitchell published the case-history findings of 62 Mongolian Idiots. This study added tremendously to the existing critical literature on the subject. In 1928, Kate Brousseau brought the literature on Mongolism up to date. Three important dates, therefore, are connected with the study of Mongolian Idiocy, 1866, John Langdon Down's establishment of the syndrome; 1876, Mitchell's study on 62 Mongolians; and 1928, Dr. Brousseau's monograph bringing the literature up to date.

The existence of the disorder known since 1866 as Mongolian Idiocy was recognized much earlier than that. It was then, however, looked upon as a special type of Cretinism associated somehow or other with parental tuberculosis.

Etiology

Incidence. Since Mongolians frequently die at an early age, it is to be expected that their relative percentage among youthful defectives is higher than among older aments. The percentage of Mongols decreases in proportion to the advancing age of the group which is diagnosed as feeble-minded. The statistics on this matter are roughly as follows:

a) Of those diagnosed as mental defectives during the first year of life, at least 40 to 50 per cent are classified as Mongols.

b) Of those under five years of age who are recognized as aments, about 25 per cent are Mongols.

c) Of 2090 aments between the ages of two and ten, 8.4 per cent were Mongols.

d) Tredgold thinks that Mongols in England are about 5 per cent of all aments.¹²

e) A study by Rosanoff indicates that 59 out of 1789 first admissions to the New York schools for aments were Mongols.¹³

Although only one case of Mongolism is usually found in any family, irrespective of its size, or of the position of the Mongol in the family, there have been several cases of two or three, and in very rare instances, four in the same family.¹⁴

Age of onset. The condition is always present from birth. No one who is normal at birth ever afterward develops into a Mongolian idiot or imbecile. In this, as in other aspects, it differs from Cretinism. The close resemblance Mongols bear to each other may be taken to indicate a definite time in foetal development when these resemblances became crystallized. The basic forces resulting in Mongolism seem to be operative not later than the seventh or eighth week of pregnancy.¹⁵

Pathogenesis. Many of the factors previously considered causal of Mongolian idiocy are now primarily of historical value. Among these may be mentioned Crookshank's theory of atavism;¹⁶ neuropathic taint; a family tendency toward tuberculosis; parental alcoholism; parental syphilis or its toxins; ill-health during pregnancy; specific

toxin; small inelastic amniotic sac; and position in the family. Recent investigations have proven these theories to be invalid.

Advanced age of parents has been thought by many to be a significant factor in the production of Mongolism. Penrose thinks that maternal age has a very close connection with the disorder. He found that the average age of the mother at birth of 573 normal children was 31.2 years. The average age of the mother at the birth of 154 Mongols was 37.2 years.¹⁷ Rosanoff also indicates that his studies reveal that the advanced age of the mother is significant.¹⁸ It must be recognized, however, that Mongols may be born to a young mother.

The germinal theory. Since Mongols do not marry or propagate, heredity strictly as such can in no way be productive of the Mongolian Idiot. It is well known that parents of Mongols are usually quite normal individuals; heredity may, therefore, be ruled out as a strictly causative factor. On the other hand, it is highly probable that germinal etiology comes nearest to the adequate explanation of the Mongolian syndrome.

The investigations on 64 sets of twins, as related by Rosanoff indicates that both twins, whether males or females, were Mongols when they were identical twins, monozygotic twins. As is evident in monozygotic twins, life began as one fertilized ovum and, in the course of development, resulted in two individuals. In such case both twins could trace the source of their Mongolism to the same fertilized cell. In dizygotic twins, on the other hand, only one was affected and that was true whether they were both males or both females or of the opposite sex.¹⁹

Nor is this opinion as to the germinal explanation of Mongolism confined to Rosanoff alone. Tredgold, who was very skeptical at the start, as to the entire Mongolian syndrome, inclined later on in his studies toward the germinal explanation as to the etiology of the disorder. He observes,

A considerable number of cases have now been recorded in which the mongol was one of twins, the other child being perfectly healthy. I have seen two such instances myself, and in neither case did the other twin show any sign of mongolism or of anything abnormal. A few cases are on record in which both twins were mongols. In all these latter the twins were of the same sex, and there is reason to believe that they resulted from the fertilization of a single ovum.²⁰

Last, we may cite Penrose who states that "There is evidence, however, that Mongolism is in some degree determined genetically."²¹

Clinical Manifestations

Signs. Four groups of symptoms are common to all Mongols and these syndromes reflect consistent peculiarities of:

- | | |
|------------------------|----------------|
| a) The head and skull, | c) The eyes, |
| b) The hands, | d) The tongue. |

Skull. The skull is small, round, and greatly diminished in anterior-posterior measurements. The cranium is invariably small. It is 5 to 10 per cent less than the average in circumference.

Hands. "The characteristic feature is a marked transverse line running straight across the palm of the hand."²²

Eyes. The eyes in about 75 per cent of cases are narrow and slitlike and slope upward and outward.

Tongue. The tongue may be constantly protruded and withdrawn from birth. It may be large and flabby or narrow and pointed. There may be transverse fissures and hypertrophy of the papillae.

Other physical manifestations less commonly found are:

a) The average Mongol is 10 to 35 per cent below the average weight for his age.

b) He is 5 to 20 per cent below the average height for his age.

c) Dentition is likely to be late and irregular and the teeth are usually small, irregular, and widely spread.

d) Preternatural mobility of the joints permits the child to assume peculiar postures.

e) Other congenital manifestations may occur and the genitalia are poorly developed.

Psychic Symptoms

The intelligence of the Mongol is that of an idiot or an imbecile. One or two per cent may reach the level of a moron. About 20 to 25 per cent of these patients never learn to talk, and most do not speak until they are six years of age or older. Most Mongols never fully master the ability to speak distinctly. Their disposition varies, but for the most part they are cheerful and good natured and seem to lack many of the bad habits so frequently found in other mental defectives. Penrose observes "the smiling face of the Mongolian Imbecile suggests the possession of a secret source of joy."²³ Many Mongols display some aptitude and skill in rhythm and dancing.

Treatment

As in all cases of mental deficiency, parents and teachers by the exercise of ingenuity and patience can do much to foster good habit formation. There is no known medical treatment for this condition. Placement in an institution seems best in most cases.

HYDROCEPHALUS

Definition

Hydrocephalic amentia results from the destruction of brain tissue because of the pressure exerted by the excessive accumulation of cerebral spinal fluid. As indicated previously, intact brain tissue is a necessary condition for the function of the psyche.

In most cases the head is normal size at birth but within a few months it displays signs of enlargement. When the head is enlarged prior to birth there is serious probability of death at birth and this frequently happens. The abnormal cranial growth takes place before the fontanelles are closed and while the bones are still quite plastic.

Clinical Manifestations

a) *Physical signs.* In hydrocephaly, the cranium alone is enlarged. The face is normal but because of its proximity to an enlarged head, it seems smaller than the normal face and somewhat triangular in shape. The head varies in circumference from slightly larger than the normal in mild cases to 30 inches or more in the severe cases. The skull is evenly and uniformly enlarged.

b) *Psychic symptoms.* In hydrocephaly, there seems to be a definite relation between the degree of mental enfeeblement and the brain tissue degeneration. Because of fluid pressure, the brain tissue close to the ventricles is gradually flattened out, and thinned and so badly damaged that eventually, in severe cases, but little tissue is left. Mild cases of hydrocephaly that early become arrested do not usually cause mental deterioration. In most cases there results partial mental deficiency. In general, the mental range of hydrocephalics is from that of an idiot to that of a moron. Special training may be productive of some improvement.

As a group, the hydrocephalics are kindly, quiet, and usually are easily taken care of.

MACROCEPHALY

Macrocephaly is a disorder characterized by enlargement of the head and face associated with a mental condition of amentia. The abnormal size is not due to any increase in actual brain tissue but in the supporting tissue cells known as glia cells. Very little is known as to the cause of macrocephaly and no proposed therapy has proved effective. "Familial incidence of such cases, however, is extremely rare and nothing can, at present, be said about an hereditary mechanism. Macrocephaly is of quite unknown origin."²⁴

MICROCEPHALUS

Microcephalus is a condition characterized by congenitally small malformed skull. It is usually associated with mental powers within the idiotic and imbecilic range. The skull of a microcephalic usually ranges from 15 to 17 inches in circumference, but may measure 19 to 21 inches. The microcephalic head is small, long, and narrow, approximating normality in length rather than in height or width.

WEIGHT OF BRAINS

The brains of various individuals differ very much in weight. The normal weight of a healthy fully developed adult brain is approximately as follows: 1100 to 1400 grams in males; average 1374 grams or about 48 ounces.

PSYCHOSES AND MENTAL DEFICIENCY

Psychoses and mental deficiency are sometimes found together, but not frequently so.

PROGNOSIS

In our present state of knowledge, little can be done for the idiots and imbeciles, but as previously pointed out, many intellectually inferior individuals can be trained to earn their own living and to conduct their own affairs with some degree of prudence. The work of Bernstein has opened up great possibilities in this field.

TREATMENT

The therapy of the feeble-minded is discouraging. The condition of idiots and low-grade imbeciles is hopeless at present. The cerebral deficiency of morons is largely unimprovable. Their limited intelligence cannot profit by the ordinary educational facilities, but they

respond well to education which is designed to make them useful members of the community. The therapy of such individuals, therefore, should be directed not toward increasing their intelligence, but toward changing their environment and teaching them how to make a proper adjustment to it.

The use of glutamic acid in the treatment of mental deficiency has recently been suggested and some results seem to indicate that it has value. No conclusive information is available at this time and it is suggested that reference be made to the current literature on this subject.

FOOTNOTES

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4. S. D. Davies, *Social Control of the Mentally Deficient* (New York: Thomas Y. Crowell Publishing Co., 1930), pp. 163-167.
5. D. A. Hauber, *Problems of Mental Deficiency*, pamphlet (Washington, D. C.: National Catholic Welfare Conference, 1930), p. 34.
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10. Tredgold, *op. cit.*, Chap. XV.
11. *Ibid.*, p. 213.
12. *Ibid.*, p. 214.
13. Aaron J. Rosanoff, M.D., *Manual of Psychiatry and Mental Hygiene*, 7 ed. (New York: John Wiley & Sons, 1938), p. 227.
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16. F. G. Crookshank, *The Mongol in Our Midst* (New York: Dutton, 1934).
17. Penrose, *op. cit.*, p. 103.
18. Rosanoff, *op. cit.*, p. 228.
19. *Ibid.*, p. 228.
20. Tredgold, *op. cit.*, pp. 215-216.
21. Penrose, *op. cit.*, p. 107.
22. *Ibid.*, p. 99.
23. *Ibid.*, p. 100.
24. *Ibid.*, p. 129.

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DISTURBANCES OF SEX

INTRODUCTION

The importance of disturbances of the sexual drive in psychiatric disorders should not be minimized. It is true that such sex problems are seldom the basic causal factor responsible for a neurosis or psychosis. However, misinterpretations, misunderstandings, erroneous attitudes toward sex, and sexual maladjustments may contribute to the development of psychiatric disorders as significant precipitating factors.

There is no area of human behavior about which there is more misunderstanding than about matters of sex. Nor is there any other form of human conduct about which there are so many false opinions. The only correct philosophy of sex is the one which indicates that the primary purpose of the sexual drive is the procreation of children. All enjoyment of venereal pleasure is secondary to this primary consideration.

IGNORANCE A BASIC PROBLEM

There is a tremendous ignorance of people in regard to the most elementary facts of sex physiology and psychology. Children are ignorant of the things they should know, and often have erroneous conceptions. Adolescents are often compelled to face the problems of that period without proper instruction. Many enter marriage insufficiently informed about the nature of marital relations. These conditions are potential factors of much psychic conflict and personality disorganization that can be largely avoided by proper instruction at the proper time.

THE INSTRUCTION OF CHILDREN

Children should be prevented from forming false concepts of the functions of sex. Such misconceptions are often excellent cultures for the development of adult maladjustments.

Some instruction in sex matters should be given to children. The exact nature of such instruction and the best method of giving it are, and will undoubtedly remain, problematical for some time. The method to be used will depend on the circumstances under which it is given. The age at which it is to be given is also a subject of much discussion. The most natural method would seem to be to answer the child's questions truthfully when they are asked, regardless of his age. This can be done at first without elaboration, later in greater detail. It is important for parents to remember that children will, out of natural curiosity, seek information about sex matters. If they do not receive it from reliable sources, they will obtain it in less satisfactory ways. It may, we think, be definitely stated that if sex be taken for granted, be given its true place in life and instruction concerning it be informally imparted, the growing adolescent is not likely to develop the idea that even normal sexual relations are "unclean, animalistic, and something to be ashamed of."

THE INSTRUCTION OF THE ADOLESCENT

The adolescent should be impressed with the idea that the sexual urge is a natural phenomenon and that its use is desirable and proper in marriage. The boy or girl approaching maturity should likewise be informed that sexual continence is not harmful or impossible. Many, who should know better, speak glibly and falsely about the desirability of free expression of sexual appetites, both inside and outside of marriage.

The young girl approaching puberty should be instructed about the menstrual function and its normality. Frequently the first menstrual period comes as a shock to the young girl who has been inadequately informed. She may develop severe, uncalled-for, guilt reactions over this normal fact of nature, especially if she has been indulging in sexual play such as petting or masturbation.

Another great danger of this period, if improperly handled, is the tendency for young girls to become invalids for the duration of the menses. This tendency is expressed by the common terms applied to the menses which refer to it as a "sick period" and of "being unwell." This erroneous attitude of invalidism is frequently fostered by the family, particularly the mother who treats the "poor child" with great solicitude. Other misconceptions of the menstrual period such as the impression that it is an excretory function and that it is "filthy" may contribute to unfortunate psychological states.

PREMARITAL INSTRUCTION

Before marriage the prospective husband and wife should receive instruction as to what constitutes proper sexual relations. It is the feeling of many that this natural phenomenon should be instinctively known by the individual. Such is not always the case. For example, there was a woman, 28 years of age, who, after six years of marriage, sought advice on how to have a baby. "My mother told me the stork brought babies. I know this is not true, but I do not know where they really come from." It developed that for the duration of her marriage she had been having interfemoral coitus and had no knowledge of proper sex relations. A very prevalent bit of misinformation is that unless the climax is reached by the woman, pregnancy will not result. Misinformation of this type is frequently a source of sexual neurosis. Other misconceptions too numerous to mention may contribute to severe psychic invalidism. There is a gradually increasing tendency to seek proper instruction from the family physician. He should be equipped to offer it.

The need for such premarital instruction is being recognized rather generally and some excellent efforts are being made to provide such instruction for those about to be married. The Marriage Preparation Service, The Catholic Center, 125 Wilbrod Street, Ottawa, Ontario, Canada, has a correspondence course which might well serve as an example for others contemplating giving such advice. The list of subjects which they choose in their correspondence course is considered so excellent that it is here reprinted with their permission for the guidance of others.

1. *The present situation with regard to marriage.* What young people think of it. The Christian ideal of marriage. How to prepare for it.

2. *The ideal husband—the ideal wife.* The qualities to look for in your partner. Defects to be avoided. The correction of faults.

3. *Love and happiness in marriage.* Love. Its elements. True love and false love. True happiness in marriage.

4. *Courtship and engagement.* The purpose, duration, place of courtship. The dangers of flirting. Faithfulness. Christian engagement.

5. *Masculine and feminine psychology.* For men: how to understand women. For women: how to understand men.

6. *Economic preparation.* Economy. The trousseau. The budget. Insurance.

7. *The spirituality of marriage.* The vocation. The sacrament. The purposes and qualities of marriage. The sacramental grace. The spirituality of marriage. The child, etc.

8. *Civil law concerning marriage.* Legal formalities. Impediments. Nuptial agreement. Annulment, separation, and divorce. Last will and testament.

9. *Canon law concerning marriage.* Prenuptial enquiry, impediments to marriage, publication of banns, conditions required for validity, etc.

10. *The marriage ceremony.* Liturgical explanation. Events before and after the marriage ceremony: showers, wedding outfit; confession; Communion; reception, honeymoon, etc.

11. *Masculine and feminine anatomy and physiology.* The plan of God. The personal and social role of purity.

12. *Relations between husband and wife, pregnancy, nursing, birth.* The mystery of the transmission of life. The beauty and grandeur of God's plan.

13. *Hygiene—venereal diseases.* General and sexual hygiene. Diagnosis and therapeutics of venereal diseases. Social consequences.

14. *What is allowed and what is forbidden in marriage. The moral aspect.* Continence. The Rhythm System.

15. *The first months of marriage.* The first relations. Physical, intellectual, and moral adaptations. The child.

THE SEXUAL NEUROSES

Any type of neurosis may develop on the basis of sexual conflicts. The wide prevalence of such conflicts justifies their separate consideration. In some fully developed neurotic pictures there may be no conscious sexual element, but in other instances the conflict is projected to the sexual organs and results in impotence, frigidity, vaginismus, and other psychosexual disturbances.

Etiology

It is impossible to enumerate all the disturbances that may lead to neurotic symptoms. Some of the more common causes are:

1. Ignorance of sexual matters which may occasion feelings of inadequacy or guilt.

2. Erroneous attitudes toward sex, due to defective education.

3. Various neurotic patterns predicated on habits of masturbation, promiscuity, or other sexual irregularities.

4. Prolonged engagements associated with excessive petting, especially when it includes "all but intercourse."

5. Abstinence from marital relations due to disease or refusal of one of the partners.

6. Fears of pregnancy, venereal disease, distaste for the sexual partner may be strong enough to occasion neurotic behavior.

7. Abnormal attachment of one of a married couple to his or her parents may cause trouble.

Symptoms

As indicated above, neuroses based on a sexual conflict do not differ from the ordinary neurotic patterns and manifest themselves frequently in typical psychoneurotic patterns.

CASE 64: *Trismus Due to Guilt Caused by Masturbation*

This 25-year-old married white female sought help because she was unable to open her mouth. The history showed that as a child she vomited almost every morning. For years after she first went to school she was extremely self-conscious when called upon to recite. She had always been an habitual worrier. She was married five days before her soldier husband was sent overseas. He remained there for almost three years. Prior to marriage, she had very little instruction about sexual matters, and during the brief honeymoon sexual relations were very unsatisfactory. After her husband left she indulged in much sexual fantasy and developed sexual tension. "About this time my aunt gave me a book which said that release from tension could be obtained by masturbation. I tried it out and found relief, but I began to worry about whether it was right or not. I felt guilty every time I did it."

During the period of masturbation and remorseful reactions she had a tooth extracted which was immediately followed by the inability to open her mouth. For over one and one half years various surgical efforts failed to help. After a short period of psychotherapy the trismus disappeared.

Quantitative Disturbances of the Sexual Drive

These are characterized by excessive increase or decrease in the degree of the sexual drive. The most important of these are:

1. Psychic impotence,
2. Premature ejaculation,
3. Frigidity,
4. Nymphomania,
5. Satyriasis.

Psychic Impotence, Premature Ejaculation, Frigidity

These three conditions can be discussed together because they are closely related. Psychic impotency is the counterpart of frigidity. Their etiology is similar. They differ in that impotency in the male renders the marriage act impossible, whereas frigidity in the female still permits the completion of the act and even impregnation. There is *one type of frigidity*, namely *vaginismus* in which there is active interference with the marriage act to such an extent as to constitute true impotence on the part of the woman. *Vaginismus*, which in its primary form is considered psychic in origin, may be defined as an involuntary spasm of the vaginal muscles and other muscles making up the pelvic floor, arising upon the attempts of sexual relations. This reaction is associated with a strong contraction of the adductor muscles of the thigh and a drawing away of the pelvis.

Psychic impotency in the male consists not only of the inability to obtain an erection (*impotentia erigendi*) but also failure of *ejaculation* (*ejaculatio deficiens*) or *premature ejaculation* (*ejaculatio precox*) of such a degree as to prevent a proper marriage act.

Frigidity in women (sexual anhedonia, anesthesia, anaphrodisia, dyspareunia) consists chiefly of the *absence of sexual pleasure or even revulsion for sexual relations*, usually psychic in origin. It occurs in 60 to 80 per cent of women in marriage. In many cases sexual desire may be present, although satisfaction is lacking.

Physiologically, the dilation of the arteries of the penis or clitoris during erection is a reflex act. The reflex center is in the lumbar portion of the spinal cord and the efferent impulses are carried in the pelvic nerve (*nervus erigens*). The afferent pathway for the reflex is through the pudendal nerves. Stimulation of the erogenous zones (glans penis, clitoris, breasts) may reflexly give rise to erection of the penis or clitoris, but this usually does not occur unless there is a corresponding erotic stimulation of the higher centers.

Erotic phantasy is, therefore, an essential part of the mechanism for proper sexual relations and it is in this respect that those who are psychically impotent are at fault. The occasions for sexual stimulation in either sex, whether these be sights, contacts, odors, or words, give rise to erotic phantasies in which such occasions appear as pleasurable and there is an associated preparation of the sexual organs for the completion of the act. If, on the other hand, such occasions give rise to unpleasant, fearsome, or repulsive phantasies, the reflex

does not take place and there is no effect on the organs involved. Most psychic impotence and frigidity is explainable on this basis. One of the simplest cases of psychic impotency to understand is that of the young man who sought treatment for impotency. He was in great distress and stated that he had repeatedly tried to have sexual relations with his girl friend but had been unable to obtain an erection. Questioning elicited the history that his attempts were being made on the sofa in the living room of his girl friend, while her father paced around upstairs calling down at frequent intervals, "When is that young man going home?" It is not difficult to imagine that an image of the impatient father interfered with his erotic phantasies and broke the path of the reflex.

The same thing happens in most of the other cases, although they are not as easy at times to visualize. The permanence of psychic factors depends to a large extent on how deeply rooted they are in the personality. Many of them may be relative but are certainly permanent as far as the particular individual is concerned.

Etiology

More specifically the causes of psychic impotence and frigidity may be listed under the following headings:

1. Fear

Fear may in a variety of ways interpose an image which will eliminate the erotic feeling such as fear of consequences as in the case above, fear of disease, and fear of pregnancy. Feelings of inferiority which give rise to a fear of the inability to complete the act are a frequent source of temporary impotence on the part of the male. Roughness or inept attempts at intercourse may cause such pain and tension on the part of the woman that it gives rise to permanent frigidity. There is associated in her mind the relationship of pain to sexual relations. Incorrect ideas of how the act should be performed and attempts to proceed before the woman is properly prepared frequently make the husband the agent producing frigidity in his wife.

2. Revulsion

Many women and some men are conditioned to a rejection of their role in regard to sex by faulty attitudes which they acquire from their parents. Frequently at a conscious level they recall remarks from their parents, usually their mother, that the sex act is "not

nice," "a sin," "a filthy habit," "animalistic." These early training inhibitions and faulty education are common sources of difficulty. A point frequently overlooked by those so affected is that there is no necessary conflict between the sexual urge and religious conscience. Less common difficulties arise from some disfigurement of the sexual partner, such as skin disease or some habit or other characteristic not discovered before marriage which give rise to a feeling of disgust, hate, or shame.

3. *Guilt*

Feeling of guilt is a frequent source of conflict. Guilt over masturbation, previous sexual relations, venereal disease, or even over-imagined sexual irregularities is commonly expressed. It is not unusual for a man to express the idea that he has too much respect for his wife "to use her." If he really feels this way it is usually an expression of guilt over previous experience or over extramarital relations.

4. *Lack of a Proper Stimulus*

Under this term may be included such conditions as homosexuality, sexual perversions, and hermaphroditism. Some homosexuals are able to indulge in heterosexual relations before indulging in homosexual phantasies preliminary to the act. Individuals conspicuous for self-love may be unable to transfer their love to another.

5. *Fatigue*

This is a common source of temporary impotence. Not only physical fatigue but mental fatigue may give rise to difficulty. Neurasthenia, excessive indulgence in sexual relations, or excessive stimulation as in prolonged engagements with much sexual play may also be factors.

6. *Drug Addictions*

Although small amounts of alcohol increase libido, and by lowering the level of inhibition promote sexual promiscuity in predisposed individuals, excessive indulgence in alcohol is a frequent source of impotency, not only during the spells of overindulgence, but also later in the relatively sober periods. Drugs such as morphine, cocaine, and others are sometimes sources of impotency.

Most of the *psychic causes of impotence are relative*. Many of those who are unable to perform the sex act properly in marriage are able to do so outside of marriage or are able to masturbate. From

the list of factors enumerated it can easily be seen how this could come about. Many women who are frigid in their first marriage can have satisfactory relations in their second marriage. *The treatment of psychic impotence by psychotherapeutic methods is frequently satisfactory, but there are many failures.* The therapeutic result depends largely on the causative factor and the depth to which it is implanted in the personality.

Nymphomania is an excessive sexual desire in the female.

Satyriasis is an excessive sexual desire in the male.

Both of these are probably most often of psychogenic origin.

QUALITATIVE DISTURBANCES OF SEX

Qualitative disturbances of the sexual drive include those states in which sexual stimulation and satisfaction is derived from some other than a normal source. The principal qualitative disturbances are:

- | | | |
|-----------------|------------------|-------------------|
| 1. Fetishism | 6. Scopophilia | 11. Bestiality |
| 2. Masturbation | 7. Sodomy | 12. Necrophilia |
| 3. Sadism | 8. Exhibitionism | 13. Prostitution |
| 4. Masochism | 9. Cunnilingus | 14. Homosexuality |
| 5. Pederasty | 10. Fellatio | |

1. *Fetishism* consists of the fixation of erotic interest on a part of the body or article of clothing of a loved one. This is accepted as the love object in place of the individual, e.g., sexual pleasure even to ejaculation may be derived from contact with a stocking or lock of hair belonging to a loved one.

2. *Masturbation*, also known as self-abuse, onanism, solitary vice, and other names, is probably the most common disturbance in the sexual field. No other practice has been so widely discussed and so poorly understood. It is found among both sexes, but is more frequent in boys. Children may discover its pleasurable effects either by accident or learn of it from companions. The importance of infantile erotic or pseudoerotic practices has been falsely interpreted by Freudian psychoanalysts. Such activities have nothing in common with adult sexuality. Some masturbation in older children occurs without full sexual significance. It is a source of physical pleasure without any accompanying sexual phantasy. It is only when sexual phantasies accompany or precede masturbation that it assumes the significance of adult sexuality.

Ordinarily children who learn to masturbate quickly relinquish

the practice. If and when the habit persists it is usually due to the insistence of companions, the unreasonable punishments meted out by parents, and other factors. Its persistence into adult life is an evidence of general emotional immaturity.

No harmful physical effects directly attributable to masturbation have ever been observed. When it appears as a part of a neurosis or psychosis, it is not causative but symptomatic of some underlying personality disorder. The exaggerated statements, false ideas of the harmful physical effects of masturbation have produced more psychic illness than the practice itself.

CASE 65: *Guilt Over Masturbation*

Mrs. K., white, married, aged 32, sought advice from her physician. For the past few months she had been suffering from severe headaches, morning nausea, and acute dyspepsia. Physical examination was entirely negative. Investigation of latent personality problems at first yielded no information, but since psychic conflict was obviously present, examination was continued. Suddenly she inquired, "Can you inherit masturbation?" Subsequent discussion revealed that recently she had been upset by the discovery that her six-year-old child was playing with his genitals. She decided that he was practicing masturbation. "I told my husband about it, and we both talked to the child, but I am still worried." It developed that she, herself, had masturbated for a period at the age of 16. This had never disturbed her until she discovered the child doing the same thing. The thought that her child had inherited her "filthy habit" caused strong feelings of guilt.

In treating the problem of masturbation, the age of the individual is a factor of great importance. In children harsh measures should always be avoided. Their lives should be so regulated that there is little or no free time. They should be kept busy. Any appearance of spying on them should be avoided. This, of course, does not imply that they should not be carefully observed and supervised. Children should not be allowed to remain in bed too late in the morning or forced to spend idle hours in bed as a punishment. Any local irritation of the genitalia should be corrected. This may even involve surgery. Recreation and companionship should be supervised. Outdoor exercise should be encouraged. Suggestive movies and books should be avoided.

3. *Sadism* is a condition in which the individual derives sexual

pleasure from the infliction of pain or humiliation on a person of the opposite sex. Homosexuals may derive such pleasure from cruelty to their own sex. Many evidences of sadism were apparent during the recent war in the German concentration camps. These conditions derive their name from Marquis de Sade (1740-1814), a Frenchman, who wrote novels dealing with the subject. Sadism occurs predominantly in males, but there have been some notorious female sadists.

4. *Masochism* is the derivation of sexual pleasure from the reception of pain or humiliation from a member of the opposite sex. It derives its name from Leopold Von Sacher-Masoch (1836-1895), an Austrian who wrote extensively on the subject. It is predominantly a feminine trait. Frank masochism is rarely observed.

CASE 66: *Masochism*

This 18-year-old white female reported for examination because of numerous fears, many of a sexual nature. Past history showed that since the age of 13 she had been indulging in frequent fantasies of an erotic nature in which she would picture herself being captured by a cruel pirate who would tie her up and beat her and assault her sexually. As a result of this, she would have spontaneous orgasms. In other dreams and fantasies she pictured herself as a slave who was cruelly treated by her master. The male in these phantasies was always tall, broad shouldered, and much older than herself. When asked to recall any of the pleasant episodes of her childhood days, her first recollection was of an older male cousin who used to tie her up tightly and lock her in a dark cupboard. These phantasies persisted up to the time of her marriage, which was to an immature boy of her own age who was apparently abnormally sexed. She constantly provoked him in efforts to have him treat her as she had been in her dreams, without success.

5. *Pederasty* is sexual intercourse by rectum between an adult and a child.

6. *Scopophilia* is the derivation of sexual excitation from looking at sexual objects.

7. *Sodomy* is sexual intercourse by rectum. It is a common form of relationship between male homosexuals. It is sometimes used as a means of sexual satisfaction which prevents conception or as a means of perverted satisfaction for the sexually jaded. When used as a means of birth prevention it may occasion serious psychic trauma in a normally sexed woman.

8. *Exhibitionism* is deriving sexual satisfaction from the exposure of one's sexual organs.

9. *Cunnilingus* is the derivation of sexual satisfaction from oral contact with the vulva.

10. *Fellatio* is performed by the insertion of the penis in the mouth.

11. *Bestiality* is sexual relation with animals.

12. *Necrophilia* consists of morbid sexual attraction for dead bodies.

13. *Prostitution* or sexual promiscuity for remuneration is not usually classed as a sexual perversion. In one sense it can be so designated, i.e., that it uses the sexual instincts for a purpose not intended by nature. Most prostitutes are frigid. Houses of prostitution are exclusively for use by males. Similar places for the use of women have been unsuccessful because of the nature of the sexual impulse in women which is slowly aroused and usually only by one in whom she has a strong affective interest.

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HOMOSEXUALITY

HOMOSEXUALITY

Definition

Homosexuality or inversion may be defined as a "perversion characterized by a desire for sexual relations with members of the same sex."¹ When females are involved it is also known as Lesbianism or sapphic love.

Classification

Homosexuality may be latent or overt. When overt, it is usually divided into two types:² (1) Pseudohomosexuality (also called environmental) — behavior brought on by circumstances, as in the case of prisoners or sailors; under normal conditions members of the same sex have no appeal for these individuals. (2) Genuine homosexuals — for these, only persons of the same sex arouse the specific sensations and affective phenomena together making up sexual appeal. Of this type we note a subdivision: (a) acquired (psychosexual homosexuality) — in those who owe their condition to early environmental influences; (b) inborn (constitutional) — in those born so, who cannot change. Either men or women may be homosexuals; likewise, either may be dominantly or exclusively the active or passive partner. Our interest centers in the "genuine" homosexuals and particularly in determining whether the distinction between acquired and inborn homosexuality is warranted and valid.

Etiology — Inborn or Constitutional Homosexuality

Some reason to an organic cause because they allege that the homosexuality of the patient appeared as primary and spontaneous with no previous heterosexual indulgence. The reasoning is fallacious. Granting the facts are true, we may conclude that these *may* be evidence of an organic cause; certainly, if there were an organic cause we would expect the situation to develop in this way. But until all other possibilities are ruled out, we have from such facts no strict evidence that an organic cause must be present.

The theory of an inborn type of homosexuality was propounded by Krafft-Ebing and furthered by Magnus Hirschfeld.³ The former held that this type was accompanied by various functional and anatomical signs of degeneration as well as neurotic and psycho-neurotic conditions. The theory seems to rest on the assumption that at a certain point all human embryos are organically hermaphrodite. In the normal growth pattern, one type of sexual organ regresses while the other develops; but if the regression of the heterosexual apparatus is incomplete, then the individual becomes a homosexual, displaying certain developmental defects or stigmata of degeneration.⁴

Some look upon homosexuals as a normal group lying between men and women, an intersex variety of humans. Theodore Lang was prominent in formulating the hypothesis identifying the homosexual as a sex intergrade, but the evidence is not conclusive.⁵ Under such a theory, we would expect the facts to show results traceable according to the laws of heredity; yet no such hereditary influence is clearly demonstrable.⁶

Again, if homosexuality is innate and marks a constitutional difference from either true masculinity or true femininity, one might reasonably conclude that the homosexual would display definite physical characteristics. From the data available there does seem to be evidence pointing to the appearance among male homosexuals of indications with a trend toward a feminine physique. Even so, male homosexuals as a class are much closer to the male norm than to the female norm. Masculinity and femininity do include, as Hirschfeld suggests, a vast number of mental and physical traits; while it is possible that possession of an as yet unknown group of such traits gives an individual a leaning to homosexuality, nothing in the evidence demonstrates that homosexuality is biologically completely determined, so one may conclude that there are no specific physical characteristics which distinguish the homosexual. Glandular disturbances may give a male a feminine habitus or give a female external male configurations, but this has no direct bearing on homosexuality.

The possibility of glandular influence in the matter led to a study of hormone ratios in homosexuals and normal individuals. Moore notes that "in this respect for some reason homosexuals as a class differ from normals as a class; but there is such overlapping in the quantitative measurements that one cannot say that a certain excess or defect of androgen or estrogen determines homosexuality."⁷ Treat-

ment by hormone extracts, transplantation and endocrine therapy, have produced disappointing results; such procedures may bring exterior physical changes, but the interior drive, while it is intensified, does not undergo a change of object. In eunuchoid individuals with undeveloped testes, there sometimes exists a pseudohomosexuality which disappears when androgen is administered and is followed by testicular development. However, if no sexual activity preceded the treatment, homosexuality may appear. Hence, androgen seems necessary for *some* sexual experience but does not determine it specifically.

The popularity of the notion of innate homosexuality was noted in various sources. An article in the *Enciclopedia Universal Ilustrada* refers to *inversion-perversion* (opposed to *inversion-perversidad*, an acquired vice) as a form of innate mental degeneration;⁸ similarly, an article in *Meyers Lexikon* states that homosexuality may be innate (*angeboren*) or acquired (*erwarben*).⁹ In the *Saturday Review of Literature* an admitted homosexual writes, "Homosexuals certainly know full well that they did not will themselves into homosexuality. Sexological opinion confirms the fact that homosexuality is innate and unchangeable. . . ."¹⁰ In the same periodical one Morris Bishop writes, "Professor (Frank) Beach (of Yale) grants that Gide's major thesis (in *Corydon*, a defense of homosexuality) has been sustained by science: homosexual activities are not biologically abnormal and unnatural. . . ."¹¹ The author of *The Invert*, himself a homosexual, restricts himself to saying that the underlying causes are yet an unsolved problem with evidence for both schools, i.e., those holding to inborn causes and those affirming the acquired nature of the perversion;¹² he himself seems to feel that while the influence of heredity is uncertain it would provide the best field for study.¹³

Moore's conclusions on this point may be summed up as follows: It is doubtful that homosexuals are anatomically distinct; even granted that they are, the question remains—is it a normal deviation or a pathological type? Apart from the hypothesis, evidence does not differentiate homosexuals as a class separated from men or women as clearly as men are separated from women, and *vice versa*. Moreover, the idea of homosexuality as due to some unfathomable force in nature compelling one to act as he does is a creation of the homosexual mind, a parataxis of defense. From an empirical, scientific point of view, the major factors in the occurrence of homosexuality are psychic in their nature rather than organic. From the philosophical and biological point of view, any displacement of the sex drive that

makes impossible the attainment of the proper end of the sexual function must of its nature be abnormal. Accordingly, homosexuality and its fruitless acts must be a pathological condition, whether the underlying pathology is of a psychic or an organic character.¹⁴

Acquired Homosexuality

As earlier noted, even those who hold that there is such a thing as inborn or constitutional homosexuality do not by any means affirm that all cases are of this type. Krafft-Ebing, for instance, was of the opinion that at least some homosexuality was acquired, conceiving it as underlying a process of development in three stages: in the first, the homosexual feels the inversion of his sexual trend and recognizes it as abnormal (he may seek medical aid); in the second, called *eviratio* or *defeminatio*, the psychic personality has been altered—the homosexual man, for example, feels and acts as a woman and does not want to be a man (any attempt at cure has little hope of success); in the third and last stage, termed *metamorphosis sexualis paranoica*, the patient has a fixed delusion that he is a woman, either believing he has the sexual organs of a woman or explaining his evident masculinity as the product of malign influences.¹⁵

According to Moore, most authorities will admit that some homosexuality is due to mental factors appearing in the course of the individual's life, while some think that all homosexuality rests on a psychological basis—this last represents a strong trend at present.¹⁶

An attempt to trace the etiology of homosexuality brings out the fact that very frequently, if not always, the homosexual has had unhappy parent-sibling relationships. Bender and Pastor, in their study of twenty-three children, unearthed a common factor—inadequate family life during their infantile period of growth. Most of the parents were emotionally unstable. Parents of the same sex as that of the homosexual were either grossly abusive or else played a negative part or were absent; parents of the opposite sex were either nondominant or oversolicitous, and a certain amount of seduction was apparent in some instances. The lack of a control group in this study lessens its effectiveness and reliability.¹⁷

But these men are not alone in selecting such factors as significant. Studies drawn from homosexuals in the armed services indicated that many came from broken homes. In many cases, the boy had been brought up by his mother as a girl, or had been the only son in a large family of girls. Again, a discussion springing from *The*

Sexual Criminal, a book by Paul de River, brought out that the first signs of sadism appear about the fourth or fifth year when parental influence is greatest; if the father is cruel to the mother, the boy may hate the father, whereas if the mother neglects him he may come to hate all women.

But it is true that a child must depend on someone. If around the pubertal age the child discovers a homosexual protector, then a love which might have been nonsexual may acquire a sexual component, perhaps strongly developed if that protector is looking for a homosexual outlet.¹⁸

There are cases involving an overprotective parent who keeps the child (of the opposite sex) too closely tied to himself or herself through puberty and after. Since the child comes to feel that a heterosexual outlet would entail infidelity to the parent, homosexuality may well result.¹⁹

Most psychoanalytic theorizing turns on the concept of the male child's overevaluation of the male organ which he fears to lose because of a mutilation threatened by a scolding parent. Hence the child comes to regard women as genital defectives and is seized by a *horror feminae*. Against this hypothesis, however, it may be said that the castration complex does not appear to be universal, nor even frequently present.²⁰

Among the environmental factors, education and occupation seem, on the basis of evidence, to have an influence on the development of masculinity and femininity, but nothing conclusive can be established.²¹

One element of the environment must always be considered—the existence of a society of homosexuals in every large city. The adolescent or the curious may be caught into its practices. Here a question of proper laws comes to the fore. There may be a reason to modify existing laws, but Moore feels that they should not be repealed outright, basing this stand on the following considerations: Homosexuality is to a large extent an acquired abnormality and propagates itself as a morally contagious disease. As such, it tends to erect a special society, unproductive and harmful. It is not correct to say that because all homosexuals are biologically determined they have rights that society must allow. Certainly, not all homosexuality is biologically determined; much, if not all, is to a great extent the outcome of psychological factors. Besides this, it is not clear that those homosexuals in whom there may be a biological trend to

perversion cannot with proper effort make a normal heterosexual adjustment. In any case, he concludes, laws should not presuppose biological foundations, but rather consider the homosexual as a mental patient and take due steps to control the spread of psychological causes.²²

Incidence

In the Kinsey Report²³ it is stated that 6.3 per cent of the total number of male orgasms is derived from homosexual outlets. Other estimates are: Havelock Ellis, in England, during 1936, estimated that 2 to 5 per cent of all males, and double that figure for females, were homosexuals; Hirschfeld (1903) estimated 2.3 per cent of males were homosexual; Hamilton (1929) 17 per cent of males; Ramsey (1943) 30 per cent of 291 junior high school boys; Finger (1947) 27 per cent of 111 college males.

In estimating the percentages of homosexuality, it is very important to remember that homosexuality is not a way of acting but a way of thinking. Therefore, the fact that an individual performs a homosexual act does not immediately classify him as a homosexual. A heterosexual individual can perform homosexual acts. Homosexuality is a way of thinking and the important characteristic to be sought in diagnosing the condition is the *desire* to have sexual contacts. An individual can be a homosexual and never perform an act. One may also be married and have children, and hence be living a heterosexual life, and still remain a homosexual.

Symptoms

1. *There are no specific characteristics that distinguish the homosexual.* Many overt homosexuals may make a display, adopt traits of the opposite sex; male homosexuals may dress as women and wear lipstick and rouge, but the majority of even overt homosexuals exhibit little in their external appearance that would suggest their perverted sexual instincts.

2. *The relationship between homosexuals may have all the elements of a true heterosexual love.* The invert is not a person who has sexual impulses toward members of his own sex in addition to his normal impulses but *in lieu* of the normal sex impulse. This may be noted in the following extract from the remarks of a female homosexual about her companion:

I've had a bad week, because D. has turned back to me in part. Having

her a little dependent and warmer than she has been, has made it rough. Every time I leave her I live only till the next time I can see her and do something for her. I would do anything in the world for her. I am afraid that when she gets over it, she will go away like she did before. I cannot eat or sleep, I am so jealous of anyone near her, especially boys. There is one boy who has been doing so much for her. Seeing her dependent on him made me almost sick with jealousy. I don't want to be with anyone but her. She has not been so dependent as I would like her to be. I keep wanting to buy her things, do things for her, to do anything to bring her back. One of my friends is here from out of town, but I haven't wanted to be with her, even though she is my next best friend to D. The only time I can have any free thoughts is when I am with her. I can't picture anything in my thoughts without her.

Members of the opposite sex may be desired as intellectual companions, but *never* as a sexual partner. The thought of having heterosexual relations usually brings on a feeling of revulsion, which may be characterized by physical symptoms.

3. *Transvestitism* is a variety of homosexuality in which the individual derives sexual pleasure from dressing in the clothes of the opposite sex. *Lesbianism* is the term used to refer to female homosexuals.

4. In the homosexual relationship, one of the partners is usually more aggressive and is known as the *active partner*. This individual is usually the more masculine of the pair and selects as his companion an individual of a more effeminate type who is the passive partner. In this relationship they may live together very much as a husband and wife.

Prognosis

Moore seems, at first glance, to be optimistic, saying that a long and tedious psychiatric treatment is not always necessary, as Stekel appears to indicate.²⁴ But we might note that it is not altogether clear that Moore is referring to a real cure; he may be speaking of that adjustment whereby the homosexual, still laboring under his inversion, externally conducts himself as a normal or near-normal heterosexual.

Treatment

The only treatment of value is psychotherapy. This must be intense and prolonged if any success is to be expected. Only those homosexuals who sincerely desire to be cured are likely to persist in therapy.

Those who seek help because of some external threat but without any real inner desire for help are not likely to profit by treatment. As a preliminary to treatment, it must be made clear to the patient what an important part his will plays in therapy. It should be made clear that while he may not be able to control his desires, he can control his actions by an act of the will. His control of his sexual impulses is a good indication of his will to recover from his undesired state.

In addition, one must "awaken in the patient a desire to become a normal man and lead a normal life . . . to do this one has to make the patient realize that his homosexuality is not inexorably determined by the laws of heredity or his own physical constitution."²⁵

FOOTNOTES

1. Thomas V. Moore, "The Pathogenesis and Treatment of Homosexual Disorders," *Journal of Personality*, Vol. 14, No. 1, Sept., 1945, pp. 47-83.
2. See *ibid.*, pp. 47-49, and John R. Cavanagh, M.D., *Notes on Subjects Important for a Study of Pastoral Medicine*, 1946, p. 142.
3. Moore, *op. cit.*, p. 48.
4. *Ibid.*, pp. 48-49.
5. *Ibid.*, p. 62.
6. *Ibid.*, pp. 57-59.
7. Moore, *op. cit.*, p. 64.
8. "Uranismo," *Enciclopedia Universal Ilustrada*, Vol. 65, Madrid, 1929, pp. 1301-1302.
9. "Homosexualität," *Meyers Lexikon*, Vol. 5, Leipzig, 1926, pp. 1754-1755.
10. "Letters to the Editor," *Saturday Review of Literature*, Vol. 32, No. 28, July 9, 1949, p. 26.
11. Morris Bishop, "Normal and Abnormal Confessions," *Saturday Review of Literature*, Vol. 33, No. 4, January 28, 1950, pp. 13-14.
12. Anomaly, *The Invert* (London: Bailliere-Tindall-Cox, 1948), pp. 37-38.
13. *Ibid.*, pp. 92-93.
14. Moore, *op. cit.*, pp. 49-50.
15. *Ibid.*, p. 48.
16. *Ibid.*, p. 51; also see Cavanagh, *op. cit.*, p. 143.
17. Moore, *op. cit.*, p. 52.
18. *Ibid.*, p. 53.
19. *Ibid.*, p. 53.
20. *Ibid.*, pp. 54-55.
21. *Ibid.*, p. 55.
22. *Ibid.*, pp. 56-57.
23. Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin, *Sexual Behavior in the Human Male* (Philadelphia: W. B. Saunders Co., 1948), p. 624.
24. Moore, *op. cit.*, p. 81, and note on p. 71.
25. Moore, *op. cit.*, p. 71.

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RESPONSIBILITY IN MENTAL DISORDERS*

Much has been written concerning the history of criminal responsibility. For many centuries the intention of the wrongdoer was ignored. He was considered innocent or guilty on the basis of his act alone without regard for his intention or premeditation. It is only in comparatively recent times that the law has taken cognizance of these facts, which the moralists of the Church have recognized from the very earliest days. Familiar to every school child is the statement that to constitute a grievous sin there must be "a serious matter, sufficient reflection, and full consent of the will," and yet until very recent years all except the first was ignored by the law. Thinking men have at all times recognized the necessity of accounting for their actions to some supernatural power. As Cammack so clearly states, "all recognize that in the normal man there is some factor which makes him answerable for his actions to a higher authority, for approval or blame. Responsibility, therefore, presupposes the liberty of the agent and implies the consciousness of his obligation to account for his actions." It is "accountability for conduct, in the case of an agent possessing knowledge of the moral law, with power to govern conduct in harmony with such law."¹

BASIC CONSIDERATIONS

Before specifically discussing the responsibility of certain categories of mentally ill patients, it is important to lay a groundwork for our discussion. A basic question in this regard is the individual's freedom to act or not to act. Without such freedom there could be no guilt. Present-day psychiatry has a very marked tendency to limit seriously or even to deny man's freedom of action. A great deal of this confusion has arisen because Freud thought that he had shown that free will is an illusion. He based this contention on his explanation

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of a number of psychic activities, such as the association of ideas, the origin of neurotic symptoms, meaningfulness of slips of the tongue, and purposeful acts of forgetting. But anyone who understands Freud's theory and who simultaneously understands the doctrine of free will will immediately see that the instances he offered in proof against free will do not pertain to the question. All of the conditions upon which an individual makes a free decision are in *consciousness* at the time that he makes the decision. That is to say, the premises upon which he decides to act or not to act are conscious premises. The unconscious may and undoubtedly does influence these thoughts, but however much these conscious thoughts may be *influenced* by unconscious factors, the individual's decision is based not upon these unconscious influences but upon those thoughts immediately available in consciousness. This is true for the psychotic individual as well as his more normal confrere.

THE WILL

The whole theory of criminal law is based on the concept of the freedom of the will, i.e., the ability of an individual to act or not to act. If an individual does not have this freedom, he should not be punished, because the act which he performed was not his responsibility. It is on this theory that "insanity" is a defense in a criminal case. The individual's freedom to act in accordance with reality is considered lost or diminished because of his mental illness. Menninger observes:

The legal problem of responsibility evidently involves the philosophical problem of "free will." Philosophy still debates the difficult issues of the question, and science can hardly give a final answer to them now. But the law stubbornly maintains that the question is closed. According to the law, all persons of certain categories possess absolute freedom of will, and all persons of other categories possess none. Neither science nor philosophy can accept such a conclusion.²

In spite of many opinions to the contrary, it is clear that the freedom of the will is not merely a philosophical problem but a daily practical one. To many psychiatrists the will is a theologico-metaphysical concept. For them it is beyond the pale of scientific consideration. It is difficult to understand how anyone, no matter what his metaphysical background, could fail to recognize in practice the existence of human freedom. We all act on this assumption.

This freedom is easily recognized in our daily activities, for example:

1. Everyone recognizes his own freedom of action.
2. Everyone holds others responsible for various injuries or damage which one has suffered at their hands.
3. Everyone acts upon the belief in the power of his own initiative.³

These three factors in addition to one's daily experience in the matter of free choice add up to free will.

The freedom of the will should be thoroughly understood by all those who deal with people. Absence of free will makes man a machine or an animal—neither one of which would be considered responsible. Determinism is strongly emphasized by many. If man's acts are determined, he cannot be held responsible and no one should be punished for his acts.

The freedom of the will, although frequently denied, is not entirely overlooked in medico-legal writing. For example, in the Durham case the court paid at least lip service to the concept of free will when it commented:

The legal and moral traditions of the western world require that those who, *of their own free will* and with evil intent (sometimes called *mens rea*), commit acts which violate the law, shall be criminally responsible for those acts [*italics are the authors'*].⁴

Dr. Overholser, writing in *One Hundred Years of American Psychiatry*, says:

A voluntary application is a form of contract which is valid if the patient is competent and is *acting of his free will* [*italics are the authors'*].⁵

THE WILL AND IRRESISTIBLE IMPULSE

The expression "irresistible impulse" connotes a distortion of the power of the will itself. This term is inaccurate. It is not the power of will itself that has been distorted. If the patient had entertained reality judgments which were different from those he did have, he might have chosen to act in another manner. The distortion is not of the will, but of the whole person—as the writers hope to show by a brief outline of the psychosomatic unity of the human person.

THE UNITY OF MAN

Man is a unitary being who possesses a vast number of capacities. These capabilities are divided into three broad genera: intellectual,

sensile, vegetal. The intellectual activities are those of intellect and will. The sensile involve the external and internal senses plus the whole gamut of emotions; the vegetal involve his activities of nutrition, growth, and reproduction. All of these capacities necessarily tend toward their natural goals which are called their natural goods. In the case of the will there is only one irresistible object — i.e., the infinitely good. That is to say, if the intellect were to recognize an object as being the infinite good, the will would have no other choice than to accept it. On the other hand, if the intellect recognizes an object as less than infinitely good, the will is free to accept or to reject the object.

The will tends to accept any good which is less than infinite if the intellect does not recognize, in the acceptance, a threat to an even greater good. This is the way in which intellect and will would act in an emotionally mature individual. The intellect would have a regulating and integrating role over the sensile and vegetal activities.

However, it must be kept in mind that intellect and will are not the only capacities of the whole human person. Man is an emotional, sensile, and vegetal being as well as an intellectual being. The person may choose to cultivate his sensile life at the expense of his intellectual life. Such a person may establish fixed habits whereby his emotional capacities react more readily than the intellectual, and the emotional obtain their satisfaction at the expense of the person as a whole.

The regulating and integrating rule of the intellect is never a despotic one over the lower powers, even in the most perfectly integrated human personality. Its rule is rather a democratic one. That is to say, the lower powers have some autonomy of their own, and if they are not regulated, will break out and take over the person. But even here the question of responsibility is not to be ignored. If an individual's life is a chaos of emotions, we cannot say that he has lost his will power. What should be said is that the individual has not exercised his will power, not that his will was overrun. In determining guilt the question will arise: "To what extent did the person knowingly allow his emotions to take ascendancy?"

If a person's emotional life is emphasized at the expense of his higher powers, it may be due to a number of factors, such as poor training by his parents. This would be a mitigating factor so far as guilt is concerned. On the other hand, an individual may have

allowed his emotions to take over simply because he chose the path of least resistance. In this case, he would be far more guilty than in the other.

In both of these last two cases we should speak of an "unresisted" urge but never of an "irresistible" urge.

In brief, the will is indirectly influenced by the emotions and unconscious factors but never coerced. The will acts on the basis of *conscious judgments* and inclines toward the judgment which is presented to it as good.

THE WILL AND THE PSYCHOTIC

How does the will function in the psychotic person?

Let us consider how one arrives at a conclusion of right and wrong. The individual is subjected to many forces, principally those from the environment and those from his unconscious. He may not be fully aware of the significance of either of these and, of course, both are affected by habit. If he has been accustomed by training to act in a certain way, he is likely to act in that way. If he has previously reacted in an antisocial way, each succeeding antisocial act becomes easier to perform as it becomes habitual. (On the other hand, moral conduct becomes easier as it is habitually performed.)

In any case, when a judgment is formed it is arrived at by ideas of which *the individual is fully aware*. These conscious thoughts are the only ones available to the patient (and to the psychiatrist) in arriving at an understanding of what ideas influenced the judgment which caused the individual to act in such a way as to get into the hands of the law. The question of responsibility hinges upon these ideas which influenced the judgment which led to the act. *It is for this reason that the writers feel that the ability to distinguish right from wrong is not a symptom, as stated by the Court in the Durham case, but a deduction arrived at by a study of the total facts available about the patient.*

The difference between the normal man and the psychotic is the *degree of influence* which is exerted on his actions by the unconscious. In the normal man the power of reason has control over the urges arising from unconscious sources. In the psychotic, the power of reason yields its place more readily to these urges. Thus reason is unseated because its control has been usurped by the lower powers. Just why reason is overwhelmed in the psychotic depends on a large number of factors, the most important being the loss of proper

subjective judgment which permits the effects of childhood trauma, more immediate environmental influences, psychic threats, faulty habits, and other traumatic psychological experience to gain access to the conscious without the usual controls. The normal and the abnormal minds do not differ qualitatively but quantitatively. The sensitive conscience of the psychotic may lead to swift and terrifying behavior.

ALL ACTS ARE NOT FREE

It should be clearly understood when we speak of free will that we do not maintain that all acts of man are free. On the contrary, there are many acts which a man performs which are not free. Only those acts which follow deliberation are free acts (see p. 152). That is why the philosopher distinguishes between an *actus humanus* and an *actus hominis*. Human acts (*actus humanus*) are those specific acts resulting after a man exercises his human power of deliberation. Acts of a man (*actus hominis*) are those actions which take place without deliberation, e.g., reflex activity, digestive activity, response to stimuli, growth. Habit and bodily appetites may influence the judgment which precedes the act of the will and consequently may strongly influence its action. The will in this latter case, although influenced, is not coerced.

Freedom of will does not mean arbitrariness as if the will simply moved at random. On the other hand, we should not say that influences coerce the will into a position where it can choose only one alternative. We all know how often we have had the chance to choose between two motives and we may have chosen something which at the time was less desirable than something else. For example, going to work at the office on a pleasant day, instead of playing golf. Most of the arguments against freedom of the will are based on a nineteenth-century concept of Newtonian physics, or upon the law of the conservation of energy. In back of the doctrine of psychic determinism is the nineteenth-century philosophy of mechanism which Freud adopted uncritically from his contemporaries. Freud himself was not a philosopher, as he pointed out somewhat ironically in his own autobiography. Nineteenth-century mechanism has been rejected because in more recent times even in the physical universe it can no longer be held that there is absolute determinacy. We are referring, of course, to the Heisenberg Principle.

RESPONSIBILITY

Webster's Dictionary defines *responsible* as "capable of determining one's own acts, capable of being deterred by consideration of sanctions or consequences." Menninger uses the word *responsibility* in the sense of punishability, "responsibility in the legal sense means punishability."⁶ Jacoby states: "In order that a person who has committed a punishable wrong may be held responsible for his act, it is necessary to assume he possesses sufficient insight to enable him to recognize the punishability of the unlawful deed."⁷ Webster in speaking of responsibility states:

This distinction has given rise to the legal concepts of responsibility, the basis of which rests upon the relation of the mental condition of the person to his knowledge of the nature and quality of the act, and whether or not he had sufficient power of will to restrain the impulse to commit the act.⁸

Davidson attempts to reconcile the medical and legal concepts of responsibility:

It is frequently alleged that the law is inconsistent for supposing that a person could be legally insane and medically sane, or vice versa. However, this is not the state of affairs. When a psychotic patient is convicted of crime he is not thereby declared to be "legally sane." He is merely held to be legally "responsible," that is, "answerable" for his acts. The distinction between insanity and responsibility is perfectly valid. As every psychiatrist knows, some psychotic patients do respond to fear of punishment or promise of reward (that is, they are "responsible" — they respond) and others do not. There is a vast sociologic difference between these two groups of psychotic persons.⁹

This problem of "legal sanity" and "medical insanity" seems to bother a good many psychiatric writers. However, as Davidson pointed out, there is no inconsistency here. If the psychiatrist will make an attempt to understand the legal terminology, it should be clear to him that psychosis and insanity do not have the same meaning as we will attempt to point out later (p. 578).

Hinsie and Shatzky¹⁰ do not define the term *responsibility*. Henderson and Gillespie¹¹ discuss the matter but give no definition of their own. Overholser and Richmond,¹² Noyes,¹³ and Skottowe¹⁴ fail to define *responsibility*.

Most of the psychiatric texts fail to discuss the subject because they consider responsibility a strictly legal consideration.

Responsibility in its derivation means ability to react to a situation, that is, to respond to punishment or to be deterred by punishment.

RESPONSIBILITY VERSUS GUILT

There is frequent failure to understand the difference between responsibility and guilt. The writers are presumptuous enough to believe that they can detect this error in the G.A.P. report. It seems to presume that the psychiatrist who says that an individual is responsible is finding him guilty. How else is one to understand such a statement as the following:

Often the psychiatrist learns too late that the existence of psychosis as such at the time of the offense does not automatically exempt the offender from punishment. He knows that the psychosis about which he is testifying involves a very distinct appreciation of society's judgments of "right and wrong," but finds too late that in affirming this he has answered so as to convict the defendant.¹⁵

This concept is certainly in error. The examination of an individual to determine his responsibility for his acts is clearly a psychiatric function regardless of what method is used to come to this conclusion. Having arrived at such a conclusion, the psychiatrist has completed his part in the matter. The further determination of whether the individual is guilty is a matter for the judge and jury. *Guilty* is defined by *Webster's Dictionary* as "justly chargeable with, or culpably responsible for the fault or crime."¹⁶ Comparison of these two definitions, i.e., for responsibility and guilt should remove all doubt as to their distinct difference. Responsibility means only that the individual, who is under examination, at the time he performed a certain act or acts, was in such a state of mental health that he was able to act freely on the basis of a proper subjective evaluation of his act or acts, which subjective evaluation was in accordance with objective reality. This is the evaluation which the psychiatrist is asked to make. If, on the basis of this opinion, the individual is punished, it is a separate action in which the psychiatrist plays no part.

SUBJECTIVE AND OBJECTIVE REALITY

This last statement requires further discussion. *To be responsible*

the individual must be able to distinguish subjective ideas of right and wrong from the objective reality of right and wrong. In other words, a person may judge subjectively that he was doing right whereas objectively he was doing wrong. For example, a man may have the idea that the speed limit on a highway was seventy miles per hour, whereas, if he read the highway signs he would realize that the limit was fifty. If this man were driving his car at sixty-five miles per hour, *subjectively*, he would believe himself to be doing right whereas a highway patrolman might catch up to him and tell him that he is breaking the law.

To carry this example further. The man who believed that the maximum speed on the highway was seventy miles per hour (whereas the maximum really was fifty) might drive his car at eighty miles per hour. In this case, he still has a misapprehension of the maximum speed, yet he knows that eighty miles is excessive and that he is doing wrong.

Let us take another possibility. Suppose that the maximum speed on the highway is still fifty miles per hour but the driver believes the maximum speed to be forty. Suppose that he is driving his car at forty-eight. Subjectively he will believe himself to be doing wrong, whereas objectively he is doing right.

There is a fourth possibility: Suppose the maximum speed limit is still fifty miles per hour. The man has a misapprehension of the speed limit and believes it to be forty miles per hour. He, therefore, decides to keep within limits by driving at thirty-five miles per hour. In this last case the driver is subjectively right, and he is doing right in the objective order.

There are thus four possibilities on the judgment of right and wrong:

1. A man may believe subjectively that he is doing right, whereas the act itself is wrong.
2. A man may believe subjectively that he is doing wrong and the act itself is wrong.
3. A man may believe subjectively that he is doing wrong, whereas the act itself is right.
4. A man may believe subjectively that he is doing right and the act itself is right.

Responsibility for his act will be based upon the patient's subjective judgment of himself as acting rightly or wrongly. There is little

doubt, however, that when reference is made to the McNaghten Rule of responsibility, the question of right and wrong here refers to *right* and *wrong* of the objective order. That is to say, the mentally ill man to be irresponsible must have misapprehensions of objective reality, like our driver in the first possibility. The mere presence of misrepresentations of reality does not in itself relieve a man of responsibility. Such misapprehension must be due to mental illness. It will undoubtedly relieve him of any guilt, if he sincerely believed, on the basis of his misrepresentations, that he was doing right. Mere ignorance or lack of sophistication would not relieve him of responsibility.

To illustrate this point, let us refer to the Durham case.¹⁷ According to the psychiatric testimony, Durham had the following symptoms:

He was hearing false voices. He suffered from hallucinations. He believed that others [employees and others] in the store talked about him, watched him. [He believed] the neighbors did the same, watching him from their windows, talking about him.

According to his mother's testimony, "He seemed afraid of people." But note what Durham concludes from these premises: There ought to be steel bars on his bedroom windows—which is a perfectly consistent subjective conclusion on the basis of the misjudgments he has already made.

When the psychiatrist is attempting to determine the criminal responsibility of a mentally ill patient, he should consider a further point: Was the decision to commit the crime directly connected with the patient's mental state? Because an individual has some mental derangement, it does not follow that he is incapacitated in every respect. Although the derangement affects the whole individual, it may manifest itself clinically in only one area. For example, although a person who suffered from an obsessive-compulsive reaction in the field of sex may have diminished responsibility for a sex crime, there would be no reason to affirm that the same individual was less guilty than anyone else if he were caught robbing a bank. His responsibility is disturbed principally in the field of his disorder.

TESTS OF LEGAL RESPONSIBILITY

Until July of 1955, the test of legal responsibility in the United States was the McNaghten Rule. This was the basis for determining criminal responsibility in every state of the Union and in the

federal courts, both civilian and military. Briefly, the McNaghten Rule states that to escape responsibility for his crime, the mentally ill defendant must show that:

At the time of committing the offense he was laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing or if he did know it that he did not know he was doing what was wrong.

In a few states and in the military service, the "irresistible impulse" was also accepted (q.v.).

In July, 1955, the United States Court of Appeals for the District of Columbia introduced another test for determining mental responsibility. In *Durham vs. United States*, the court stated that unless the jury

believed beyond a reasonable doubt either that he [the accused] was not suffering from a diseased or defective mental condition or that the act was not the product of such abnormality, it must find the accused not guilty by reason of insanity.

They further stated that disease is

A condition which is capable of either improving or deteriorating [while a defect exists, when there is present a condition] not considered capable of either improving or deteriorating and which may be either congenital or the result of injury or the residual effect of a physical or mental disease.¹⁸

It should be noted that this decision makes no distinction between "mental defect, disease and derangement" and "defect of character, will power or behavior."

This criterion is now the law in the District of Columbia but to the best of our knowledge the Durham Decision has not been accepted in other jurisdictions and has been rejected by the U. S. Court of Military Appeals.

OBJECTIONS TO THE DURHAM RULE

Before discussing the McNaghten Formula, some objections to the criteria offered in the Durham decision are pertinent.

1. The criteria offered are vague. It is especially not clear what the court means by saying that the criminal action must be the "product" of mental abnormality. Many human actions, whether criminal or not, may be the "product" of some mental abnormality,

but the individual may be completely responsible. In its use of the term "disease," the court fails to distinguish between mental illness as we usually think of it, and character defects. It would seem that under the Durham decision, the psychopath should be acquitted. The decision gives to the jury no direction and they would be required to make decisions concerning degrees of responsibility which would be a problem for experts.

2. The decision by giving so broad a concept allows each court with its emotionally toned and perhaps biased opinions to establish its own criteria. This could easily lead to unfairness, especially since there is so little real understanding of psychiatric problems by members of the judiciary.

3. If the jury is to make the decision as to whether or not the individual is mentally ill and if he is, whether the offense was the "product" of this mental illness, the verdict is quite likely to be influenced by the sympathies and prejudices of the jury rather than based on objective evidence. To us it seems strange that many of those who speak so disparagingly of the use of the jury in commitment procedures have so readily espoused the Durham decision. For example, Isaac Ray, who is quoted frequently and favorably by the court in the Durham decision, is thus quoted by Zilboorg:

Ray's views on juries and criminal cases in which the plea of insanity was interposed are fresh and daring. He says the juries are "manifestly unfit" to solve the question of insanity in a criminal case. For a jury "to decide a professional question of a most delicate nature and involving some of the highest interests of man is an idea so preposterous that one finds it difficult at first sight to believe that it was ever seriously entertained."¹⁹

A more recent writer, Dr. Overholser, also takes a dim view of juries in cases of insanity.

Cases of this sort, criminal and civil alike, could be multiplied indefinitely. They all merely go to show that juries being composed of men and women subject to human frailties are often governed by emotions rather than reason. We should, perhaps, not be too astonished that juries are occasionally misled when subjected to emotional outbursts and psychiatric pontifications on the part of the Judge.²⁰

The G.A.P. report in commitment procedures says this about the jury in such procedures:

The worst features of contemporary commitment laws are . . . emphasis of lay judgment as in trial by jury.²¹

If lay judgment is so poor in a commitment procedure where an error is easily correctible, why is it so desirable to allow the jury to make the decision where it may well be a matter of life or death?

4. It is stated that under this decision the psychiatrist can speak in a psychiatric frame of reference. This offers nothing particularly new, since in frequent court appearances we have been encouraged to describe the psychiatric aspects of the case in our own terms. Offering psychiatric discussion of unconscious factors in the causation of the crime will add little to clarify and much to confuse the issues of the case. We wonder if, in testifying, the court will permit the psychiatrist to answer the question as to the causal connection between the illness and the crime? The psychiatrist's description is naturally going to depend upon his own school of thought. We also wonder how the court will reconcile its own necessary acceptance of human freedom in the case of the psychiatrist who denies this freedom. How will the court reconcile the testimony of those psychiatrists who believe that every criminal act is the result of sickness? Many more such questions could be asked. Many well-known psychiatrists are of the opinion that a psychopath is mentally ill. How will the court reconcile this with the opinion of other experts?

5. The courts' definition of mental defect and disease is unsatisfactory.

6. The courts' description of an irresistible impulse is unsatisfactory.

7. The introduction of the concept of the unconscious to the jury can lead to nothing but confusion. As we have pointed out above, the unconscious may influence, but the elements for a judgment are conscious at the time the judgment is made.

8. We agree with Hall when he states that the Durham test ignores cognition.

It ignores the rational element of purposive conduct, or at best insinuates it in under a spacious [*sic*] mantle of verbal imprecision; it ignores the question that is crucial, from the perspective of the law — whether the accused was competent to make the relevant moral decision.²²

THE McNAGHTEN RULE

In most of the states and in the military service, the McNaghten Rule still constitutes the criterion for the determination of mental

responsibility of criminal offenders. A few comments on the various elements of this formula may not be amiss. According to the McNaghten Rule, to escape responsibility for a crime the individual must prove that at the time he committed the offense he was

1. suffering from such a defect of reason from mental disease
2. as not to know the nature and quality of his act
3. or if he did, he did not know that the act was wrong

These elements need further explanation:

1. "*Defect of reason from mental disease.*" If the psychiatrist, having made his examinations, finds no evidence of mental disorder, there is no point in proceeding to the rest of the formula. Here, as in the Durham decision, there is no distinction between mental illness and character defect. In the military code this distinction is clearly made.

2. "*Know the nature of the act.*" This means that the individual in question knows the mechanical nature of what he was doing. He would know, for instance, that if he pulls the trigger of a loaded gun it will be discharged. He would know that if he hits an individual a strong blow in a sensitive area of the body, it will do serious harm. There is usually very little problem with this part of the formula.

3. "*Know the quality of his act.*" The word "quality" in this part of the formula following various court decisions is usually understood to mean "consequences." It may also be understood as "harmfulness." This part of the formula may be the only one which would exempt the mentally defective individual, because although he may know the nature of his act, he may not be aware of all of the implications of its consequences.

4. "*Know that the act was wrong.*" It is in regard to the word "wrong" that so many psychiatrists find difficulty with the McNaghten formula. This term should not be considered in its abstract ethical sense but only as an ability on the part of the accused to make commonplace social evaluations. It is best understood to mean an act which is generally condemned by the community. It is not to be understood as the individual's idea of right and wrong, because what he considers right may be something which he readily recognizes as being against the law of the community. For example, an individual may not consider it wrong to exceed the speed limit, but he would probably know that this is condemned by the law of the community.

However, if we understand the word "wrong" in this broad sense, the psychiatrist need not be bothered by the feeling that he must make an ethical determination in the case. He merely has to determine the individual's subjective concept of whether or not the act which he committed was one which was generally condemned by the community in which he lived and whether it is, or is not, in accord with objective reality.

Most crimes require an act plus intent. This intent is generally an intent to do harm. Some crimes also require an element of premeditation. These are also considered by the psychiatrist in his examination of the individual, because the nature of the individual's illness may be such that he was unable to form the intent necessary for the commission of the crime.

The McNaghten Rule, then, is the formula which the psychiatrist must use in most jurisdictions, except that of the District of Columbia, in determining the criminal responsibility of an individual. The psychiatrist on his part, therefore, should make an examination of sufficient thoroughness to be able to answer these questions.

THE PSYCHIATRIC REPORT

The psychiatric report should give information on the following points:

1. *The Psychiatric Diagnosis*
2. *The Physical Diagnosis*
3. *The Psychometric Examination*
4. *Addiction to Alcohol or Other Drugs*
5. *Influence of Drugs Including Alcohol on Alleged Offense*
6. *The Severity of the Mental Illness of the Individual*
7. *Was the Subject Aware of:*
 - a) *The Nature of the Act Charged?*
 - b) *The Quality (Consequences) of the Act Charged?*
 - c) *The Fact That the Act Which He Performed Was Considered Wrong by Society?*
8. *Insight*
9. *Capability of Participating in His Own Defense*
10. *Capability of Forming Intent, Willfulness, or Premeditation*
11. *Evidence of Irresistible Impulse*
12. *Evidence of Amnesia*
13. *Prognosis*

A report of such scope would supply the information necessary to fulfill the requirements of the McNaghten Rule.

DEFINITION OF TERMS

With this background we would like to discuss some of the terms used in the field of legal medicine in an effort to clarify them.

As indicated above, many psychiatrists have been very resistant to the acceptance of certain legal terms because they say that they have no real psychiatric meaning. Such rigidity on their part is, we believe, unwarranted. There is no reason why the psychiatrist should not make a real effort to understand what the law means by such terms as *insanity*, *unsoundness of mind*, and *incompetency*. The law, on the other hand, would do well to attempt to understand what a psychiatrist means when he speaks of a *psychosis* and a *neurosis*. Lawyers will profit also if they will realize that there is more than one viewpoint in psychiatry, and in giving consideration to changing medicolegal concepts, they should investigate these divergencies of psychiatric opinion. The law should not accept the apodictic statements of some extremists as representative of all psychiatric thought.

Before any intelligent mutual discussion can be profitable, some semantic understanding between the disciplines is absolutely essential. Many psychiatric terms, although they have definite meaning to a physician as a result of his experience, are very elusive of exact definition. This discouraging fact was expressed by Lord Blackburn more than fifty years ago when he commented:

I have read every definition [of insanity] which I could meet with and never was satisfied with one of them, and I have endeavored in vain to make one satisfactory to myself. I verily believe it is not in human power to do it.²³

There are certain psychiatric terms such as *psychosis* which almost defy definition and this is rendered more difficult by differences of opinion within the profession. With a full appreciation of these difficulties and with complete humility we will attempt to formulate certain definitions which may at least serve as a starting point for discussion.

A. Mental Disease

The court in the Durham case defined mental disease as follows:

We use [mental] *disease* in the sense of a condition which is considered capable of either improving or deteriorating. We use *defect*

in the sense of a condition which is not considered capable of either improving or deteriorating and which may be either congenital or the result of injury, or the residual effect of a physical or mental disease.²⁴

There are in this legal definition several difficulties for a psychiatrist; namely, the use of the word *disease*, the failure to further define *mental disease*, and the repetition of the words *mental disease* in a different sense at the end of the definition.

The use of the word *disease* in regard to mental disorders is confusing because the average person, including many medical practitioners, is accustomed to think of "disease" as a condition in which there is an underlying organic pathology. A "disease" in its usual connotation is something which has a definite etiology, a definite course, and a definite termination, e.g., lobar pneumonia. The use of the term "disease" in regard to mental disorders promotes this concept, which however is not a true concept. There are a large group of mental disorders in which no tissue pathology has been demonstrated. The term could properly be used only with reference to the somatopsychic disorders (or organic psychoses) in which the psychic manifestations arise secondary to the basic physical pathology. The majority of mental disorders, however, have no such demonstrable organic pathology and are due to disturbed methods of thinking, feeling, willing, and acting. This is certainly true of most of those mental disorders which come to the attention of the courts.

The term *disease* is also misleading because it contributes to the misconception that each psychic disorder must have some specific cause, just as the specific cause of tuberculosis is the tubercle bacillus. This is not true. In reference to this term, Hinsie and Shatzky make this comment:

It is not considered in keeping with the available facts to refer to a psychosis as a disease, since the term disease is traditionally concerned with pathology of tissues. For want of a better term, psychiatrists speak of mental disorder when they refer to pathology of the psyche.²⁵

In view of this evidence, the term *disease* as applied to mental conditions should be dropped because it is misleading. The term *mental disorder* or *mental illness* is better and more in accord with the facts.

Defining *mental disorder* in terms of progression toward improvement or deterioration, as was done in the Durham case, is only partly valid. It should also be defined with reference to its severity and the degree of loss of reality sense it brings. It would seem

desirable also to include in the definition the distinction between neuroses, character disorders, and psychoses. This is especially important because the neurotic individual would, in terms of the court's definition in the Durham case, have a mental disease. He might, therefore, be considered irresponsible for his criminal offense. It would be desirable, therefore, to discard the use of the term *mental disease* entirely and to seek some better definition which would distinguish between the more serious and less serious mental disorders. Its use in no way helps to clarify the situation, and if a psychiatrist were to testify that a neurosis is a *mental disease* (which it is in terms of this definition), it could only produce confusion. Actually, this decision of the court would seem to put the burden on the jury as to whether the offender was psychotic or not. This is a task which it is ill-equipped to perform.

Mental defect in the Durham decision seems to indicate defective brain tissue. For this there is ample clinical evidence, except as noted above in regard to *mental disease*. *Mental defect* would include mental deficiency as it is usually understood. Here again the criteria for irresponsibility are liberalized because if the individual were a high-grade moron who was quite aware of what he was doing, the psychiatrist would have to testify that he was suffering from a mental defect. This could easily mislead the jury. This part of the court's definition suffers from the same defect as the first part in that it fails to take into account variations in severity. All individuals over the age of forty probably have some cerebral arteriosclerosis. This would not be likely to cause severe clinical manifestations except in a relatively small group. Most people over sixty find it a problem. In both cases it is a *defect*.

B. Psychosis

Psychosis is extraordinarily difficult to define although its meaning is well understood by psychiatrists. Its definition is attempted by very few authors. For a discussion of this subject see page 309.

C. Unsound Mind (Insanity)

This is a legal and not a psychiatric term, and since it is a legal term it is best defined in legal language. As stated above, the law is concerned with the protection of the individual and the community. There is no law which requires an individual to seek treatment merely because he is ill. The law is concerned not with

treatment but with protecting the public from damaging or dangerous effects of illness; for example, in cases of communicable disease.

It would be well, however, to remind psychiatrists in the words of Glover that the law is not primarily interested in psychopathology; it rarely goes further than to characterize certain end products of psychic tension [behavior] as socially undesirable and reprehensible, and to charge and sentence the offender accordingly. Even when, as in the case of the McNaghten Rules, the law established a relative immunity from punishment for offenders suffering from some form of mental disorder, its concern is less with the actual state of mind of the individual than with the lack of social responsibility ensuing therefrom.²⁶

Being of "unsound mind" means to the lawyer and to the court, for example in terms of the laws in effect in the District of Columbia,

that [the individual] is incapable of managing [his] own affairs, and is not a fit person to be at large or to go unrestrained, and if permitted to remain at liberty in the District of Columbia, the rights of persons and property will be jeopardized or the preservation of public peace imperiled and the commission of crime rendered probable and that [the individual] is a fit subject for treatment in a hospital by reason of [his] mental condition.²⁷

These are the words on the certificate that a lay person is required to sign. It is horrifying to most of them and meaningless as applied to a senile or arteriosclerotic patient, at least in most of its terminology. Efforts to modify it have been unsuccessful. However, in the District of Columbia it is on the basis of this certificate that an individual can be committed to a mental institution. There are similar conditions in other jurisdictions. The distinction, therefore, between the terms *psychosis* and *unsound mind* is a legitimate one. The psychotic individual, although ill, cannot be committed to a mental institution against his will unless he fulfills the legal criteria for unsoundness of mind. In the legal sense, *unsoundness of mind* and *insanity* are synonymous and should be so understood. According to Clark's *Criminal Law*, "insanity in its legal sense" is,

any defect or disease of the mind which renders a person incapable of entertaining a criminal intent; since a criminal intent is an essential element of every crime no person who is so insane that he cannot entertain it is criminally responsible for his acts.²⁸

The *Encyclopaedia Britannica* defines insanity in these words:

This term ordinarily connotes more or less severe unsoundness of mind. Though its loose usage is almost synonymous with mental disease, scientifically the term should only be applied to the mental condition of an individual who, through socially inefficient conduct, has to be placed under supervision and control. The mind is the mechanism by means of which we adapt adequately to our environment and when, through its derangement, conduct is exhibited which the community looks upon as evidence of disease and as implying irresponsibility, the individual concerned is said to be insane and the law steps in to certify him as such. Strictly speaking, then, insanity is really a social and legal term and not medical. Mental illness is a broad concept which may include very efficient members of society. No satisfactory definition can therefore be arrived at, since it would be necessary to define what we mean by insanity, which would involve us in equal difficulties.²⁹

The terms *unsound mind* and *insanity* should therefore be limited to those mental states which are sufficiently severe to require supervision and control in a mental hospital, even without the individual's consent, in order to protect him from himself or to protect others in the community from the effects of his illness.

In addition to the above, the word *insanity* may have other meanings in the law. Overholser states these as follows:

There are at least five meanings of the word "insane" or "insanity" in legal issues: 1) the lack of capacity to make a valid contract or deed; 2) lack of testamentary capacity, the ability to make a valid will; 3) the degree and type of "insanity" required to nullify capacity to commit crime; 4) fitness for commitment to a mental hospital; 5) incompetency, that is, suitability for guardianship. Thus, depending on the pertinent statute, a variety of issues of fact can be the subject of litigation.³⁰

D. Irresistible Impulse

This term has been defined variously both by the courts and by psychiatrists. One court, for example, spoke of it as "deprivation of will power to choose whether to do the act or refrain from doing it." Another court described the irresistible impulse as a cause of irresponsibility if "by reason of mental disease he had so far lost the power to choose between right and wrong and avoid doing the act that his free agency was destroyed."

It is the Army court-martial manual which provides the definition which appears to us most descriptive. It reads as follows:

A person is not mentally responsible unless he was so free from mental derangement as to be able concerning the particular acts charged both to distinguish right from wrong and to adhere to the right.

The test for irresistible impulse stated in the 1953 edition of *Technical Manual 8-240* is whether

the compulsion generating the illness was so strong that the act would have been committed even though the circumstances were such that the accused could expect to be detected and apprehended forthwith when the offense was committed.

Most of the court decisions make some reference to defective action of the will, e.g., "his free agency was destroyed" or "deprived of will power to choose whether to do the act or refrain from doing it."

In the Durham case, the Court of Appeals stated as follows:

The modern doctrine is that the degree of insanity which will relieve the accused of the consequences of a criminal act must be such as to create in his mind an uncontrollable impulse to commit the offense charged. This impulse must be such as to override the reason and judgment and obliterate the sense of right and wrong to the extent that the accused is deprived of the power to choose between right and wrong. The mere ability to distinguish right from wrong is no longer the correct test either in civil or criminal cases, where the defense of insanity is interposed. The accepted rule in this day and age, with the great advancement in medical science as an enlightening influence on this subject, is that the accused must be capable, not only of distinguishing between right and wrong, but that he was not impelled to do the act by an irresistible impulse, which means before it will justify a verdict of acquittal that his reasoning powers were so far dethroned by his diseased mental condition as to deprive him of the will power to resist the insane impulse to perpetrate the deed, though knowing it to be wrong.³¹

Following this description, the court points to the fact that some have been misled into the belief that this condition produced "only sudden, momentary or spontaneous inclinations to commit unlawful acts." We doubt if this naïve belief is held by many psychiatrists. No one skilled in clinical psychiatry would believe that an individual could act with homicidal intent one moment and have been perfectly normal a few minutes before and be perfectly normal a few minutes later.

The choice of words used in the term is unfortunate. The word

impulse is incorrect. It leads to misunderstanding. A better word, as we noted previously (p. 565), would be *urge*. In this meaning the term is more understandable. With this connotation the following example given by the court in the Durham case becomes more understandable, but not in the way that the court understood it:

The sufferer [from melancholia, for example] experiences a change of mood which alters the whole of his existence. He may believe, for instance, that a future of such degradation and misery awaits both him and his family that death for all is a less dreadful alternative. Even the thought that the acts he contemplates are murder and suicide pales into insignificance in contrast with what he otherwise expects. The criminal act, in such circumstances, may be the reverse of impulsive. It may be coolly and carefully prepared; yet it is still the act of a madman.³²

The court then concludes that the irresistible-impulse test is defective because it gives no recognition to mental illness characterized by brooding and reflection. Could it be that the court is misinterpreting its own quotation?

The example quoted would seem to be a perfect example of what would be considered an irresistible impulse (*urge*). The depressed individual broods over his imagined degradation and misery, he reflects on the future, and the feeling, perhaps aggravated by some environmental circumstance, suddenly intensifies and he yields to the thought that death for himself and family would be better than the degradation they are about to face. So he kills them. The *urge* which he had previously resisted suddenly overwhelms him and he acts. He feels that his act is right. Is not this the definition of irresistible impulse?

The definition of unresisted *urge* (irresistible impulse) which to us is most acceptable is:

An unresisted *urge* is one which, because of mental illness, so far causes the individual to lose his power of choice in regard to particular acts that in spite of the fact that he may recognize an act as wrong, he feels so impelled to act that he is unable to adhere to what he considers right.

Put in philosophical terms, this could be expressed as follows:

An unresisted *urge* is one which has developed so excessively at the expense of the other psychic powers that in comparison to this *urge*

the other powers exert negligible influence upon reason when it is called upon to make a judgment. This urge occupies the focal point of consciousness. Because it occupies this central point, it becomes the basis upon which the intellect represents an object or some course of activity as desirable to the will.

In other words, this urge has developed to such a degree that its occupancy of the whole field of consciousness for the individual precludes the entrance into consciousness of other notions which might tend to represent the urge as undesirable. Since the urge is presented to the will only as something desirable to fulfill, the individual wills to satisfy the urge. This occurs not as an isolated temporary mental illness but as part of a continuing illness which both antedates and succeeds this particular act. Instances of acts of short duration are more likely to be the result of sudden passion or anger and are not properly considered under this title.

The concept of irresistible impulse adds very little to the usual consideration of responsibility in mental illness.

THE PSYCHOPATHIC PERSONALITY

Before concluding this discussion of irresistible impulse (better described as unresisted urge), let us consider it with reference to the psychopath. The psychopath *knows* the difference between right and wrong, his subjective judgment is correct, but he has no *feeling* for right and wrong. He is amoral, he has no ethical sense. If we accept the concept of irresistible impulse as the ability to distinguish right and wrong but inability to adhere to the right, we have a perfect description of the psychopathic personality. Therefore, a clear defense for every psychopath would be the irresistible impulse. In this instance, the "policeman at the elbow test" would not apply because the psychopath would act with the policeman at his elbow.

E. Partial Insanity

The concept of monomania has been very dear to the law. To a psychiatrist such a thing is an impossibility. As pointed out above, man is a unit and the belief that he could only be mentally ill in one part of his personality would not be acceptable to the psychiatrist. It is the story of the iceberg in which only a small part shows, but where much more may be hidden under the surface. The idea of partial insanity or monomania should be discarded.

F. Amnesia

Amnesia means a loss of memory. It may be due to: (1) hysteria, (2) psychosis, (3) alcoholism, (4) head injury, (5) epileptic fugue, (6) electric shock, (7) lying.

Hysterical amnesia offers a difficult problem from the standpoint of legal responsibility. This may bring about a situation in which the individual acts but has no recollection of his actions, although it may be demonstrated beyond doubt that he did perform them. This may bring about the concept of dual personality, as in the story of Dr. Jekyll and Mr. Hyde. In such cases responsibility can be determined within the framework of the McNaghten formula by conceding for purposes of the determination that there were two personalities. The secondary personality, i.e., the one acting, is judged in the terms of the formula and then the responsibility assigned to the primary personality. For example, if an individual commits a crime in a dissociated state in such a way as to indicate premeditation, such as planning his escape and perhaps other actions which would indicate concealment, he would probably be judged as responsible. This responsibility would then be assigned to his nondissociated or primary personality.

With the exception of hysterical amnesia, the other causes of loss of memory are not likely to be sources of difficulty. Their determination does not present great diagnostic problems. Malingering is not as common as some individuals seem to feel. It can usually be detected as the result of the observation of the individual. Even an expert might be fooled if observation is inadequate, but the only real fault in such cases would be a failure to take the possibility of malingering into consideration.

In hysterical amnesia the use of the sodium pentothal interview is most useful. This is the so-called "truth serum." The courts have not been willing to accept information obtained in this way. This also holds true of information obtained through the use of hypnotism (see pp. 79, 293).

RESPONSIBILITY IN SPECIFIC CASES*Mental Deficiency*

Cases of mental deficiency would be judged in accordance with the McNaghten Rule having in mind that mentally deficient individuals vary in the severity of their condition. Intelligence tests will

be useful in this evaluation but will not in themselves supply an answer which will be satisfying to the court.

Psychoneuroses

The presence of a psychoneurosis is seldom of medicolegal significance. In the case of obsessive compulsive neuroses such as pyromania and kleptomania, the question of irresistible impulse may arise. There is no doubt that in such cases the compulsion to act may be very strong. Failure to act may cause severe anxiety. In such cases the "policeman at the elbow test" fails because, although it would only be at the cost of severe anxiety, the compulsive personality would probably not act if a policeman were at his elbow.

The hysterical dissociated states have already been discussed (p. 584).

Alcoholism

Simple intoxication is usually not considered a defense in a criminal case. It may, of course, so cloud the consciousness that specific intent may not be present.

In pathologic intoxication, a condition characterized by sudden outbursts of co-ordinated purposeful activity occurring usually after relatively small amounts of alcohol, in which there is amnesia for the pathological activity, the condition should be judged as in cases of dissociated personality (see p. 584).

In cases of alcoholic psychosis, it would seem that since the condition is not one which was desired or deliberately willed by the individual, it would be judged as would any other psychosis. In cases of delirium tremens, there would be no question of responsibility (see p. 427).

FOOTNOTES

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PART VII

CONCLUSION

C H A P T E R

XXXII. PSYCHIATRY, PHILOSOPHY, AND RELIGION

PSYCHIATRY, PHILOSOPHY, AND RELIGION

It is hoped that previous chapters have demonstrated that the physical sciences such as anatomy, physiology, zoology, and endocrinology are of only minor importance in the study of psychiatry. The tendency of these subjects is to treat mental disorders as organic diseases caused by tissue defect. They also usually teach that they are hereditary. This, we have indicated, was a defective point of view when dealing with mental disorders. Psychoses and neuroses are psychic and not organic disorders. Psychiatry to be successful must avoid a strictly organic interpretation of mental illnesses and accept a psychogenic explanation of their origin.

Psychiatry is, however, profoundly affected by what is currently taught regarding the nature of man, the place he holds in the universe and his ultimate destiny. Until quite recently, the philosophy upon which psychiatry was built maintained that man was the end result, the joint effect or product of four causes, the material, the formal, the efficient, and the final. These causes as applied to man are as follows. The material cause is the body. The formal cause is the soul, by which the body is animated and by whose influence man becomes capable of knowing and willing. The efficient cause is God who created the very dust that man inherits from his parents as his body and who, at the moment of conception, creates and infuses the soul into man's body. The final cause or purpose of human existence is the praise, reverence, and service of God during the day of man's earthly career, and the reward, bliss, and eternal joy thereafter.

To be of therapeutic significance, psychiatry must clearly perceive and grasp the constitutive elements of man, his nature, and his basic tendencies. Without a knowledge of man's goal, it is impossible to properly direct his energies or to supply him with help in the dark moments when the realization of his frustrations press heavily upon him. Even with a clear notion of means and goals the task is not an easy one. Without this, it is totally impossible.

TWO ANSWERS AS TO MAN'S NATURE AND DESTINY

Two radically different answers, both psychiatrically important, are being offered today as to what constitutes man's nature and his goal. These replies represent two diametrically divergent points of view.

1. That of the *materialists*, naturalists, monists, rationalists, or "scientists." Despite their various names, in practice they maintain and apply the same doctrine. For that reason, we refer to them as a unit under the caption *Materialism*.

2. That presented by those who accept the findings of dualistic philosophy and of revelation on man's nature and goal.

MATERIALISM ON MAN'S NATURE AND DESTINY

The following points are to a greater or lesser degree held by all materialists.

1. *God's existence is either ignored or denied.* God, they claim, is not at all necessary to explain the presence of reality. His existence, they furthermore add, cannot be established by experiment in the laboratory. For that reason it is denied or ignored.

2. *Matter alone is granted.* In its explanation of reality materialism excludes practically all the four causes mentioned earlier and does not, therefore, merit to be called a philosophical system. To be more exact, of the four causes none but the material cause is completely retained. As a first principle but with no scientific or philosophical basis, it is maintained that matter is eternal, and necessary, and, therefore, its own cause and goal. They forget that even were matter eternal it would still be contingent. Obviously, neither God nor the soul at all enters into the picture. Evolution, ever ancient, and yet ever new, seizes this matter, gives it myriads of shapes and forms and so stimulates portions of it that even the majority of the unwary are deluded into thinking that some objects live! Thus does man under the sway of materialism find himself the proud, though somewhat mystified, possessor of matter without form, of a vibrant essence without anything producing the vibration, in motion but propelled by nothing, and going nowhere. He is truly an enigma. Materialism is monistic and cannot, therefore, account for man's nature and destiny. On such profound matters it must forever remain agnostic.

3. *Materialism denies the formal cause, the soul.* Materialists maintain that there is no need for the soul in order to account for life.

Several of them identify life and nonlife. Others among them, who consider such a stand somewhat extreme, assert that life results from spontaneous generation or emergence and is the product of organization and structure. Though spontaneous generation and emergence have been scientifically rejected, and though organization and structure have been demonstrated to be themselves effects or results and not causes, the materialists disregard this. They consider the soul as something mystic, mysterious, a reality which would reverse the entire laws of science as well as that of the conservation of energy. The soul is, therefore, "scientifically" rejected. Since the soul, therefore, according to the materialists, is nonexistent, it is obviously not simple, spiritual, immortal, or dependent on God for creation and conservation.

The rejection of the soul is fatal to the well-being of a psychiatry which has for its purpose the cure of the soul and its powers.

4. *Mind, its tendency and activities are denied.* With the denial of the soul, the existence of the intellect or mind and its tendency toward infinite truth is treated by the materialist as a medieval myth or as a forced and fruitless hypothesis. In the denial of mind the materialists are logical, though mistaken. The mind is a power by which the soul begets ideas, and judges, and reasons. If the soul does not exist, the mind obviously does not exist. Yet, if the mind be denied, how, it may be asked, can psychiatry cure its disorders? Materialism is a sandy foundation for psychiatry.

5. *The existence of the will, its tendency and freedom are denied.* Likewise, the existence of the will, its urge or tendency toward infinite good, and its active determination, or freedom, are supplanted by the deterministic findings of "science." It is, therefore, considered "unscientific" and quite medieval to introduce any reference to free will into psychiatric discussions. There is no freedom of the will, they assert, and there is, therefore, nothing that can be done to change events because they result from predetermined causes. Thus materialism would render psychiatry a strictly deterministic science. If everything is thus determined and predetermined, what, it may be asked, can psychiatry do about it? Hence spontaneous generation, conditioned reflex, and stimulations and responses are adopted to replace the functions of the soul, mind, and will to the prejudice and detriment of all.

6. *The natural law is denied.* God's will rules the destiny of men.

In God there exists an eternal law because it is proper that an infinitely wise God should direct all beings to their proper goal through the use of means which are in harmony with their nature, i.e., by the natural law.

With the denial of soul, mind, and will, there is no power left in man's essence which is capable of receiving the natural law which makes known to him first principles as to good and evil.

7. *Man's social nature is denied.* Because of the denial of soul and its powers man is no longer considered as social by nature. If he enters into social relations with his fellow men it is, they teach, because of some definite type of social contract or previous agreement.

8. *An immutable norm of morality is denied.* With no soul, no mind, no free will, no natural law within him, and with his social nature rejected, and God's existence either questioned or denied, it follows that man has left to him no unchanging immutable standard or norm by which to judge the morality of his conduct. Contemporary ethics glories in its power to adjust itself to a changing dynamic civilization. For that reason, "modern" ethics assert that the mores in man's social milieu are sufficient norms of right and wrong, but mores change and so accordingly do norms and thus man looks in vain for something stable and unchanging that will give him the moral stability he needs. "Modern" ethics deny the need for an immutable norm of morality. The reason advanced is that they have no unchanging goal to attain. Morality, therefore, is subjective and largely utilitarian. Pragmatism asserts that the goodness or badness of objects and actions is essentially dependent on their present and immediate utility.

In the light of the above, need we be surprised when we hear of some psychiatrists who formulate and promulgate their own decalogue of science, establish their own norms of morality which change as occasion demands?

9. *Man is given no ultimate goal.* As is evident one of the most glaring defects of modern materialistic philosophy is its inability to formulate an ultimate goal for human activity. Practically all the goals of human endeavor proposed by the materialists are at best immediate, proximate, and crassly pragmatic. For that reason, man's goal is considered to be mere social efficiency or self-expression or the development of the personality or the choosing of activity that leads to further activity. Such goals for the most part are mere words, mere shibboleths, the confusion of motion for progress. Hence, mate-

realistic psychiatry does not know in which direction to lead the individual. It has no ultimate goal nor a proximate one that is truly meaningful.

Summary of Principles Maintained by Materialists

1. God's existence is either ignored or denied.
2. Matter alone is granted.
3. Materialism denies the formal cause, the soul.
4. Mind, its tendency and activities are denied.
5. The existence of the will, its tendency and freedom are denied.
6. The natural law is denied.
7. Man's social nature is denied.
8. An immutable norm of morality is denied.
9. Man is given no ultimate goal.

Materialism with its numerous pseudo-principles begets the reign of chaos. Under the sway of materialism nothing seems to fit into a definite place or to form a complete picture. Materialism produces and has always begotten wild extremes, either extreme socialism or extreme individualism. Materialistic "principles" generate a false concept of faith and religion. We witness either the outright denial of man's goal or we observe that it is shrouded in dense fogs or mist. Materialism, science, rationalism, and irreligion have become the corner stones not only of society and of man's life but of certain schools of psychiatry as well. Many modern psychiatrists are trained under materialistic auspices and they subscribe to the denials and pseudo-principles enumerated above. Need we be surprised then at the advice given by certain psychiatrists to their patients?

Thus materialistic psychiatry whose function it is to free the spirit has embraced the principles of a system destructive of soul and spirit, and it basks in the dull glow of naturalism and monism. Principles flowing from such sources are, to put it gently, intrinsically incapable of effecting mental integration and psychic stability.

The Materialist Has Conflicts and Cannot Solve Them

It is difficult to see why materialists should have conflicts. Why should conflicts arise in their lives if there be no soul, no mind, no will, no goal? Conflicts arise because the individual experiences disappointments, because he is thwarted in reaching a cherished goal. However, regardless of theory, the fact remains that materialists admit the presence of conflicts in their lives. Here alone they are realistic.

Conflicts are built on man's very nature, on his failures and reverses, on the contending urges of mind and sense, of intellect and instinct, of reason and imagination. Numerous factors, rational and nonrational, enter into his conflicts. Conflicts solved by reason generate peace and calm and assurance, a sense of victory and well-being, the dominance of spirit over matter, of the rational over the sensory, of the man over the beast.

Materialism can in no sense adequately meet a conflict. Materialism is unreal as it denies practically all reality, including God, the supernatural, the soul, mind, will, and man's goal. Materialism must forever fail to reach a satisfying solution for the conflict whose complete unraveling requires the possession of truth regarding man as known by reason and revelation.

Since materialism is unable to meet its radical conflicts, it must forever dodge and avoid them. Avoidance or flight from truth, however, offers no genuine solution to a conflict. The reality fled from is truth concerning man's nature, his goal, and how to attain it. Such knowledge is essential for psychic composure. Complete truth includes knowledge of all reality, supernatural as well as natural, God as well as soul, mind, will, and body.

Such ill-advised departure from truth, as the materialists make, denies the mind and will their proper objects and renders a psychiatry based on such tenets valueless and impossible. Under the sway of materialism, confusion supplants certitude. Man is told to solve his conflicts by the light of science and "to be scientific." Yet science as they understand it asserts that there is no God to seek, and that there is no soul to seek a God even if He did exist. Hence arises today's confusion, psychic bewilderment, mental incertitude, indecision, worry, fear, and anxiety. The mind is created to rest in truth, ultimately in infinite truth. The will is made to repose in good, ultimately in infinite good. Modern philosophy gives a sweeping denial to the existence of mind and will and to realities they seek, to the realities toward which they tend.

Modern philosophy, therefore, on which this materialistic psychiatry is built gives no adequate answer to the question of man and his destiny. Materialism denies God as man's Creator and ultimate goal. It denies the soul, the mind, the will, natural law, immutable norms of morality.

PSYCHIATRY IN THE LIGHT OF DUALISTIC PHILOSOPHY AND REVELATION ON MAN'S NATURE AND GOAL

We shall present the pertinent matter briefly as follows:

1. *God exists.* Reason and revelation are the diametric opposites of materialism. From reason it can be proved that there is a God who is necessary, eternal, and has a paternal care over His children. He is the Creator of heaven and earth and of all things.

2. *Man has a soul, intellect, and free will.* It can further be established that man is composed of a body and a soul. The soul is spiritual, immortal, created, and is endowed with the powers of intellect and free will.

3. *Man is social by nature.* Various branches of study throw further light on man's nature. He is naturally social. He enters into social relations not because of mere whim or convenience or at the imperative behest of crying need, but because of the attraction of a natural social urge.

4. *There exists in man a natural law.* The natural law is the sharing of the eternal law in rational creatures. The natural law is the eternal law revealed by the light of reason as directive of man's activity. Right and wrong, good and bad, and their general applications are thus made manifest to man. Acceptance of a natural law is part of man's nature. Man's nature completely grasped in itself and its reactions becomes the proximate norm of morality.

Psychiatry should work in harmony with the natural law as it is evident in man's nature. Psychiatry should work also to understand the nature of morality and regulate its advice to patients in terms of objective right and wrong.¹ Man is rational and should by the power of his mind and will regulate and subject his lower powers.

5. *Reason asserts that God as known through creatures is man's ultimate goal.* God has made the mind of man for the possession and the enjoyment of infinite knowledge and his will for the possession of infinite goodness. Yet all objects on earth are finite. Now nothing finite, such as honors, riches, pleasures, knowledge, friends, or any created good, can adequately satisfy man. A few reasons for this conclusion are as follows:

- a) Such realities are not within the reach of all men.
- b) Even if they were possessed, there would always be the danger of losing them.
- c) At best, under all aspects, they are finite.

Now God is both kindly and just and has not given man a mind and a will to frustrate him. There must, therefore, be some object that will satisfy man's rational aspirations for truth and goodness. That object is not a created one. The infinite God Himself is the object which will unendingly satisfy the thirst of the mind and will for truth and goodness. God is, therefore, man's ultimate goal. He is the infinite truth and infinite goodness sought by man's intellect and will.

Thus the knowledge of man's nature and of his goal as known by reason is of immeasurable significance to psychiatry. It gives point, direction, and orientation to psychiatric activity. It does not vary with the mores of one's environment nor with the passing of years.

Psychology and *ethics* afford partial glimpses of the goal of man. It is, they state, the possession and enjoyment of infinite truth, infinite goodness, boundless happiness and bliss. It is God as known and loved by the light of reason.

6. *God is present to us by His essence. We should therefore not feel alone, lonely, or deserted.* Reason establishes that God is present to us:

- a) By His essence,
- b) By His knowledge,
- c) By His power.

a) *God is present by His essence.* Much mental anguish arises because man feels himself alone and a stranger in the world that ignores him. The human soul seeks companionship. It looks for a kindred soul in whom it may safely confide. Man desires to pour into a sympathetic soul the story of his hopes and disappointments, his joys and his sorrows, his successes and his failures. How good then to know that God is always and everywhere present to hear us, console us, and comfort us.

What a source of comfort and strength it is for us to realize that God is present always and everywhere. Nature abhors a vacuum and the human heart dreads loneliness. It shrinks from the thought of being imprisoned in a solitary cell of matter, with no mind to know its hunger, and no heart to beat in unison with its throbbing. God is the answer to the cry of every heart for companionship and life and love. For God is present with us wherever we go.²

b) *God is present by His knowledge.* There is comfort in the realization that this kindly omnipotent God, our ultimate goal, fully understands us. God fully appreciates our unexpressed desires to be better than we actually are. God understands how disappointed we are with

ourselves and at times how impatient because of our ineffectual attempts to be perfect as the heavenly Father is perfect. God sees our sorrows weigh us down and how fear, worry, and anxiety becloud our horizons; how despair at times tries to capture the very citadels of our souls. God recognizes that human frailties flow more frequently from weakness than from malice. His mind is infinite and He, therefore, infinitely understands and sympathizes with the lot of the children of Adam, exiles in a foreign land.

There is not a star whirling its lonely way in the outermost stretch of cosmic space, not a bird winging its way across the trackless sky, not a blade of grass in the verdant carpets of our Western prairies, not a fish in the ocean's depths, not an insect burring its way in the bowels of the earth, not a grain of sand on the sea-shore, not an electron whirling in the unplumbed depths of a tiny atom, that escapes the all-seeing eye of God.³

c) *God, man's ultimate goal, is present by His power.* Not only does God know our difficulties but He is present by His power to strengthen us. We do not work alone. God by His creative act drew us forth from the abysmal void of nothing. He did not, however, hurl us adrift or cast us aside. He preserves us in existence by His conservative act which is the continuation of the act of creation.

God co-operates in our activity. He is concerned in all our doings. We never work alone. God's power encompasses us, leads, accompanies, and follows us. We can do all things in God who works with us.

7. *There exists a kindly divine providence.* God's divine providence is His omnipotence, His wisdom, His love, guiding and directing all creatures to their appointed end. There is not a second of our lives, a moment of our day, there is not an event of our whole existence, an action or a suffering that is not absolutely, completely in the hands of God's infinite providence.

The providence of God with respect to His children is to share with them the happiness and holiness, the beauty and perfection that are His. Most wonderful of all, He has given us a free will in order that we might co-operate with His providence, might receive Him with love in all the ways His infinite wisdom manifests His will to give Himself to us.

The wonderful wisdom of God's providence knows all the ways, all the means by which one can attain the most intimate union with Him, the fullest participation in His life, light, and love. He knows

with infallible certitude how to direct every action and every creature to the end which He has for him.

"God clothes the lily of the field as never was Solomon in all his glory arrayed."

"The insignificant sparrow does not fall without God's permission." God takes care of the birds of the air and their uncharted flight through the realms of space. Bryant tells how God's providence leads home the lone waterfowl until it rests among its fellows:

There is a Power whose care
Teaches the way along that pathless coast —
The desert and illimitable air —
Lone wandering, but not lost.⁴

His providence will also take care of men:

He who, from zone to zone,
Guides through the boundless sky thy certain flight,
In the long way that I must tread alone,
Will lead my steps aright.⁵

The divine providence will lead us:

Amid the encircling gloom
O'er moor and fen, o'er crag and torrent, till
The night is gone.⁶

The above comforting notions are derived from unaided reason. We now turn the page and let revelation tell its story as to man, his nature, and destiny.

8. *Revelation makes known to us the fact of man's elevation by grace and his sharing in the nature of God.* From revelation men know of the existence of grace and of their own personal elevation to a supernatural state or condition. Grace is the principle, the source, the cause of man's supernatural life.

Grace effects in the soul a change greater than that exercised by the soul and the body. The soul breathes life into the inert matter and gives it the power of growth, sensation, thinking, and willing. Grace is the principle or source or cause of our supernatural life. Grace is engrafted onto our natural life, it elevates it and gives to its actions spiritual significance and efficacy. Grace kindles the divine fires of faith, hope, and charity in man's life. Grace is a gift of God that makes us Godlike.

Among other effects, grace makes man:

a) A participant in the Divine Nature,

b) An adopted child of God,

c) An heir of heaven,

d) A temple of God,

e) Capable of performing actions that merit for man an everlasting reward.

9. *Grace brings God into our souls as into His own temple. We can, therefore, speak to Him as one friend speaks to another friend.* God wishes to be united to our souls, to take up His abode therein. It was previously seen that God is present to man by His essence, His knowledge, and His power. He comes, however, to our soul in a most intimate way when it is adorned by sanctifying grace. He dwells in our souls and makes them His temples. He is present as one friend speaking to another friend. Friendship characterizes this presence. There is no ceremony, no restraint; His presence is calm and reassuring. He seeks union with our souls. We call Him Father because we share in His nature and are his adopted children. As children, we can pour into his sympathetic paternal ear the account of our woes and sorrows, our joys and aspirations. The God of heaven resides within us. His wisdom becomes our wisdom, His power our power.

The above ideas are dwelt upon by St. Augustine in his *Confessions*. He stresses that the God who lives within us is alone capable of bringing joy and peace to the soul. Creatures, inordinately sought after, disturb the soul and lead man away from God. The soul must return to the fount of all bliss which is God dwelling within us:

Late have I loved Thee, O Beauty so ancient and so new; late have I loved Thee! For behold Thou wert within me, and I outside; and I sought Thee outside and in my unloveliness fell upon those lovely things that Thou hast made. Thou wert with me and I was not with Thee. I was kept from Thee by those things, yet had they not been in Thee, they would not have been at all. Thou didst call and cry to me and break upon my deafness: and Thou didst send forth Thy beams and shine upon me and chase away my blindness: Thou didst breathe fragrance upon me, and I drew in my breath and do now pant for Thee: I tasted Thee, and now hunger and thirst for Thee: Thou didst touch me, and I have burned for Thy peace.⁷

10. *Man's goal is to see God face to face as He is in Himself and not through the mere medium of creatures.* From revelation we know that man is destined for a goal which is superior to the demands, to

the aspirations, and even to the ordinary unassisted powers of human nature. This is most important in the field of psychiatry. For mental stability it is most helpful to stress the sublimity of man's goal and the relative facility with which, by God's grace, it may be attained.

11. *As God is man's absolutely ultimate goal, man should exercise religion.* Man depends on God for absolutely everything. In the natural order he depends on God for body and soul, mind and will, and all that he needs for conservation and well-being. In the supernatural order he depends on God for grace here and for glory hereafter.

Man, therefore, depends on God in a manner which is absolute, essential, and necessary. Man should bring himself to realize his dependence and return God due submission, reverence, service, and love. This is what is called religion.

The exercise of religion is the most reasonable act of man's life. Among other activities religion includes the offering of sacrifice to God and the exercise of faith, hope, and charity, of prudence, justice, fortitude, and temperance. The practice of religion since it is in harmony with man's nature begets calm, peace, and psychic tranquillity. Psychiatry should understand this, and attempt to make man aware of his essential dependence upon God and of the reasonableness of religion, of the need and value of prayer, of the need and value of the observance of God's laws, and, in a word, of a need for total conformity with God's will.

12. *Conformity to God's will does not mean individual passivity or inertia.* With regard to conformity to the will of God a word of warning may well be sounded here. Many people imagine that it is impossible to practice conformity to God's will and still be possessed of any dynamic force, or have definite goals of their own, or work with unrelenting zeal for success in life. Conformity to God's will in no sense whatsoever implies personal inertia or passivity or a laissez-faire approach to life. God gave men mind and will and He wishes men to judge, to reason, and to seek goals and make choices. Frequently, however, when we have done our utmost the end result is not up to our expectations and we must accept what seems to be relative failure. For the moment, this relative failure is God's will for us and we should not, therefore, become fearful, depressed, or anxious. We may, however, renew our efforts and see if we cannot by new and added efforts attain the goal we first envisioned. One can, therefore, be intensely active and enthusiastic and still be totally conformed to the will of God.

13. *God actually wills the crosses that come into our lives. Crosses are, therefore, not evil.* Conformity to God's will is not difficult when the sun of peace and prosperity shines on our paths and flowers bedeck them. In the hour of adversity, however, of poverty, of contempt, when injustice seems to be enthroned and to encompass us then conformity to God's will is more difficult. Still it is certain that God wills our humiliations, contempt, poverty, mortification, crosses, contradictions, sorrow, and misunderstandings. Nothing happens but by God's will. Good things and evil, life and death, poverty and riches are from God. God does not will the sin of those who injure us but he sees their impiety and uses it. God sees the injustice of the persecutors and, though not willing their sins, avails Himself of their impiety for the objects and decrees of His divine will. Conflicts, disasters, and apparently irreparable losses and humiliations are easily and even joyfully met and submitted to when one realizes that they come from the hand of a provident and all-loving God. It is a well-known spiritual axiom that whatever happens here contrary to our will happens by the will of God.

14. *Conformity to God's will removes the basis for psychic depression.* It may be truly stated that those who are completely conformed to God's will do not become depressed at life's adverse occurrences. Contempt, contradictions, misunderstandings, and injustice take on a different hue when man sees them coming from God's hand for his spiritual betterment, and not primarily from the malice of his enemies. God wills the sickness, sorrows, disappointments, and conflicts which harass men. They are sent to make men prayerful and patient and united to God and not for their unhappiness. God is never wrong in whatever He wills for ourselves or others. We should, therefore, welcome whatsoever He sends us, be it prosperity or poverty, health or sickness, honor or dishonor. Conformity to God's will as it comes to us through His varying decrees brings peace, rest, security, contentment, calmness in tribulation, strength in affliction, and joy. There is no place in such a soul for the effects of paralyzing depression.

15. *Nature points the way to peace and calm.* There is peace and calm and stillness in the elements and solar system as they silently execute God's will as voiced in the necessary laws which govern them. The flowers bud, grow, and blossom because they live in harmony with God's will as manifested in nature's laws which regulate them. In the planetary and vegetative realms there are no conflicts, no worries, and no anxieties. Tempests but make the plants take deeper roots.

Storms do not kill their life or their growth. They are firmly established and are at rest. Nothing upsets or perturbs them.

16. *Lack of conformity to God's will is a cause of conflicts.* It is in man alone that incapacitating, paralyzing conflicts are encountered. Man finds life's challenges at times unpleasant and disconcerting because he does not realize that they come from the mind and will of an infinitely wise and kindly God. We must accept and be conformed not only to God's word but also to God's work or activity. "Who hath resisted him and hath found peace?"

17. *Conformity to God's will excludes fear.* A deep spirit of faith, of trust, and of love gives the absolute assurance that there is nothing to fear, that God regulates our lives, that He is present with His grace to strengthen us to meet contradictions, to carry the cross of pain and suffering, to understand the divine plan underlying misunderstandings and injustices. Faith in God, hope in God, and love of God remove the foundation for the emotion of fear. Infinite wisdom affirms that perfect charity casteth out fear.

18. *Conformity to God's will excludes anxiety.* Anxiety arises from danger real or imaginary, is usually nonspecific, at times is overwhelming, and always begets tension. But again we are exhorted at this juncture to cast our cares upon the Lord, not to be unduly solicitous concerning what we shall eat or drink or wherewith we shall be clothed. He has care over us.

God is the good shepherd. He will follow us and rescue us from amongst the brambles and briars.

He is the Hound of Heaven. He will pursue us and give us no peace until we surrender ourselves and all our concerns to Him.

He has paid too high a price for us to let us fall by the wayside and be lost. There is "plentiful redemption" with the Lord. There is in God's mind a universal salvific will. God wishes all men to be saved. His grace assists us in every way and manner.

He is the father of the Prodigal. He worries not about the past so long as we return to Him. He tells the servants on the return of His prodigal son to "Bring forth quickly the first robe, and put it on him, and put a ring on his hand, and shoes on his feet: And bring hither the fatted calf, and kill it, and let us eat and make merry: Because this my son was dead, and is come to life again: was lost, and is found."

Nor will He reject us because we come or return to Him when the day is far spent. Even the eleventh hour workers are rewarded.⁸

19. *Conformity to God's will excludes inferiority feelings.* Conformity to God's will excludes inferiority of feelings or that state of mind characterized by inadequacy, incompetency, and unworthiness. It is known by faith that our strength is from above.⁹

20. *Conformity to God's will begets true wisdom in man's life.* Conformity to God's will establishes true wisdom in the soul of man. It teaches him that true success is success in the sight of God, and that it consists in carrying out God's will, and thus securing one's ultimate goal. Tranquillity then takes possession of one's life. There is begotten in man and in his activities a proper subordination of means to a goal. Joy enters into man's soul and life and therein takes its abode. "Your joy no man shall take from you."¹⁰ "Whatsoever shall befall the just man it shall not make him sad."¹¹ He well knows that "Good things and evil, life and death, poverty and riches, are from God."¹²

21. *Conformity to God's will makes us Godlike.* To be conformed to God's will is to be one with God because God is identified with His will. We, therefore, become Godlike when we accept His divine decrees, conform ourselves to them, and pray that His will may be done on earth as it is in heaven. Man's gaze then gradually becomes directed toward the eternal horizons. In his father's house there are many mansions. In peace and calm and hope and trust he awaits the darkness of life's evening, when the shadows shall lengthen and the Lord will come to take him to His own home that where He is the creature also may be and forever. "There are many dwelling places in my Father's house; otherwise, should I have said to you, I am going away to prepare a home for you? And though I do go away, to prepare you a home, I am coming back; and then I will take you to myself, so that you too may be where I am."¹³

There the eternal Father shall wipe away the tears and sorrow shall be no more. Present sorrows are not worthy to be compared to the glory that shall be revealed in us. Such a man worries not amid the vicissitudes of life, amid its joys and sorrows, its sunshine and shadow, its smiles and its tears. He progressively shares in the eternal calm, peace, and serenity of an unchanging God. He realizes that "To those who love God all things work together unto good."¹⁴

22. *Complete conformity with God's will is not easily achieved.* Those individuals who are unable to achieve such perfection should not be discouraged. They should continue to strive with the assistance of prayer to seek such acceptance and in the meantime by both natural

and supernatural means seek the truth which will resolve their conflicts.

Psychiatry should also be encouraged to follow along the way which has just been indicated. It would then be of much greater significance for the individual, for society, for time, and for eternity.

FOOTNOTES

1. Sigmund Freud, *A General Introduction to Psychoanalysis* (New York: Liveright Publishing Corp., 1935), p. 377.
2. John A. O'Brien, *Truths Men Live By* (New York: The Macmillan Co., 1946), p. 90 sqq.
3. *Ibid.*, p. 100.
4. William Cullen Bryant, *To a Waterfowl*.
5. *Ibid.*
6. John Henry Cardinal Newman, *Lead, Kindly Light*.
7. Aurelius Augustinus, *The Confessions of St. Augustine*, trans. by F. J. Sheed (New York: Sheed and Ward, 1942), Book X, Section XXVII.
8. Mt. 20:1-6.
9. Job 9:4.
10. Jn. 16:22.
11. Prov. 12:21.
12. Eccles. 11:14.
13. Jn. 14:2-3.
14. Rom. 8:28.

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GLOSSARY

No attempt has been made to include all psychiatric terms in the glossary. Most of the terms included are those in common use. If a word is not found here, reference should be made to the chapter on the "Examination of the Patient" where a more complete list of symptoms will be found. Many psychiatric terms will be found defined in the regular dictionary. For specific psychiatric expressions not found here, reference should be made to a psychiatric word book such as the *Psychiatric Dictionary*, by Leland E. Hinsie and Jacob Shatzky, published by the Oxford University Press.¹

ABULIA. Lack or defect of will power.

ACROCYANOSIS. Blueness of the hands and feet.

ACROMEGALY. A disease marked by enlargement of the tissues of the face, hands, and feet, due to oversecretion of the hypophysis or pituitary gland.

ACROPHOBIA. A morbid dread of heights.

AFFECT. The emotional tone associated with an experience.

AGORAPHOBIA. A morbid dread of open spaces.

AGRAPHIA. Inability to express ideas in writing.

ALIENIST. One who studies mental disease from a criminological or anti-social standpoint.

ALZHEIMER'S DISEASE. See PRESBYOPHRENIA.

AMAUROSIS. Blindness without apparent defect in the eye.

AMBIVALENCE. Contrasting emotions, such as love and hatred, experienced at the same time in the same person, one emotion of which may be unconscious.

AMENT. A person whose mind has never developed; idiot, imbecile, moron.

AMNESIA. Loss of memory.

ANALGESIA. Insensibility to pain.

ANAMNESIS. Synonym for history.

ANAPHRODISM. Frigidity. Absence of sexual feeling in women.

ANESTHESIA. Absence of sensation in any part of the body, including the skin.

ANHEDONIA. Absence of pleasure in acts that are normally pleasurable.

ANOREXIA. Loss of appetite.

ANXIETY. A pathological fear state characterized by an abnormal fear of things only remotely possible.

APATHY. Lack of feeling or emotion; indifference.

APHASIA. An impairment or loss of the faculty of understanding or reproducing language.

APHONIA. Loss of voice.

- APRAXIA.** An impairment or loss of the power of using objects correctly.
- APROSEXIA.** Inability to fix the attention on any object.
- ARCHETYPES.** Legacy of patterns of thinking and feeling, the inherited tendencies or ways of thinking occurring among all racial groups.
- ARGYLL-ROBERTSON SIGN.** Loss of pupil reflex to light with retention of accommodation reflex.
- ARITHOMANIA.** A morbid tendency to count.
- ASTASIA-ABASIA.** A condition, usually hysterical, in which the patient is unable to walk due to lack of co-ordination although, while supine, he has complete co-ordination.
- ASTHENIC CONSTITUTION.** Refers to the type of body structure characterized by a long thin body, long neck, and long extremities, also called leptisome type.
- ATAXIA.** Lack of muscular co-ordination.
- ATHLETIC CONSTITUTION.** Refers to the type of body structure characterized by well-built, well-balanced extremities, muscle, and skeleton.
- AUTISTIC.** Subjective mentation.
- BABINSKI'S REFLEX.** Extension instead of flexion of the toes on stroking the sole of the foot.
- BEHAVIOR.** "A form of conduct as involved in social relationships" (Wile).
- BEHAVIORISM.** A term coined by J. B. Watson in 1913 to indicate that all habits may be explained in terms of conditioned glandular and motor reaction.
- BINET-SIMON TEST.** A series of tests for measuring the intellectual capacity, devised by Alfred Binet and Theodor Simon, originally for children, but applied with modification to adults, especially the feeble-minded.
- BRADYLALIA.** Slow utterance of words.
- CARPHOLOGIA.** Picking at the bedclothes. Same as "Floccillation."
- CATALEPSY.** A condition associated with muscular rigidity and loss of will, without alteration in circulation (*cerea flexibilitas*).
- CATATONIA.** Sometimes spelled "Katatonia." A form of schizophrenia, characterized by periods of excitement or stupor, and showing symptoms of *cerea flexibilitas*, echolalia, mutism, etc.
- CATHEXIS.** The investment of emotional significance in an activity, object, or idea.
- CAUSE.** That which produces an effect.
- CENSOR.** In psychoanalysis, an inhibiting force of some kind — an instinctive force, not free will — which prevents the ideation in consciousness of some unwelcome urges from the unconscious.
- CEPHALALGIA.** Headache.
- CEREA FLEXIBILITAS.** Waxlike flexibility; a condition in which the limbs can be molded into any desired position, usually a symptom of schizophrenia.

CHOKED DISK. A swelling (edema) of the optic nerve head usually due to inflammation or increased intracranial pressure.

CHOREA. A disorder characterized by irregular, spasmodic, involuntary movements of the voluntary muscles.

CIRCUMSTANTIALITY. Facts are told with much unnecessary detail and great spontaneity, but the object in view at the beginning is ultimately reached.

CLAUSTROPHOBIA. A morbid dread of enclosed places.

COMA. A state of profound stupor.

COMA VIGIL. A form of stupor in which the eyes remain open.

COMMITMENT. The legal process whereby an individual is placed in a hospital for mental disorders.

COMPLEX. A group of ideas which have become associated with a repressed wish or emotional experience and may influence behavior, although the person may not be aware of the complex or have an appreciation of the connection between the forgotten desire and his thoughts and actions.

COMPULSION. An irresistible impulse to perform some act contrary to one's better judgment or will, felt by patient to be pathological but forced on him.

CONATION. The action of that portion of the personality which strives.

CONDITION. Something required in order that a cause can act; e.g., light is a necessary condition for vision.

CONDUCT. The sum total of the reactions of an individual through the will.

CONFABULATION. The invention of imaginary experiences to fill in the gaps in memory.

CONFLICT. The struggle between two opposing desires or courses of action.

CONSCIOUS. That part of mental life, proportionately infinitesimal, of which the individual is aware at any given time.

CONSCIOUSNESS. According to Dalbiez, the act whereby a person knows himself through (1) proprioceptive sensations, (2) sensory consciousness, and (3) intellectual consciousness; according to Pillsbury (1911), man's awareness of his own acts and their antecedents.

CONSTITUTION. The physical character or make-up of an individual.

COPROLALIA. The morbid impulse to use sacrilegious or obscene words in the midst of ordinary conversation.

CRETIN. A mental defective whose condition is due to a congenital deficiency of the thyroid secretion.

CYCLOTHYMIA. A fluctuation of mood in which periods of excitement and despondency alternate, a miniature manic-depressive psychosis.

DARWIN, CHARLES ROBERT (1809-1882). A British naturalist who evolved the most widely known theory of evolution.

DEFENSE REACTION. A reaction more or less unconsciously made to avoid some unpleasant situation.

DELIRIUM. A disordered mental state usually characterized by excitement,

illusions, hallucinations, and disorientation. It is usually the result of a febrile disease.

DELUSION. A false judgment. (See **PARANOIA**.)

DEMENT. A patient, once normal, with a defective mind.

DEMENTIA PARALYTICA. A term used synonymously with general paralysis and paresis.

DEMENTIA PRAECOX. A form of functional mental disease, an old term for schizophrenia.

DEMONISM. A condition in which the patient believes he is possessed by an evil spirit.

DEPRESSION. A dejection of mind, a lowering of the vital processes.

DEREISTIC THINKING. Thought which goes on below the level of awareness and is not governed by the logic of experience, as is the case when thought is directed by conscious awareness. It finds its origin in complexes, wishes, instincts, etc., in the unconscious and exists for the purpose of providing substitute forms of satisfaction of needs, wishes, and desires.

DERMAGRAPHIA. Autographism. A state in which marks or words written upon the skin leave more or less persistent traces.

DETERIORATION. A lowering of former standards of habits and conduct due to mental disease.

DIPLOPIA. Double vision.

DIPSOMANIA. A morbid and uncontrollable craving for alcoholic beverages.

DISORIENTATION. A condition in which the patient is unable to correctly state the time and place and identify persons.

DISTRACTIBILITY. A disturbance of attention in which the direction of thought frequently changes because of external impressions.

DRIVE. The energy which prompts an individual toward a certain type of behavior.

DYNAMIC PSYCHOLOGY. That form of psychology which deals with the operation of mental forces.

DYNAMISMS. A specific force operating in a specific manner or direction.

DYSPAREUNIA. Painful sexual intercourse.

DYSPLASTIC CONSTITUTION. That type of bodily build which deviates from normal and is usually the result of endocrinopathy.

ECHOLALIA. The repetition of the words of another.

ECHOPRAXIA. The repetition of the acts of another.

ECSTASY. The state of being uncontrollably swayed by excessive emotion, as joy. In such states, association with the outer world is so completely interrupted that an absolute analgesia exists.

EGO. That part of the organism that assumes the task of harmoniously gratifying our needs and desires. It is a product of learning.

EGOCENTRIC. Self-centered.

EGO MANIA. Abnormal self-esteem.

EGO DEFENSES. Devices employed to meet the emotional needs of the personality.

EMOTION. The physical expression of an inner feeling.

ENDOCRINE. The glands of internal secretion.

ENDOCRINOLOGY. The study of the glands of internal secretion, their reaction and effects upon the body.

ENDOCRINOPATHY. A study of the diseases of the glands of internal secretion.

ENDOGENOUS. Originating within the body.

EONISM. Transvestitism: the tendency to adopt the manners and dress of the opposite sex.

EPILEPSY. A chronic cerebral dysrhythmia characterized by periodic loss of consciousness, usually associated with convulsions and amnesia for the attack.

ERGOPHOBIA. Morbid dread of work.

ERGOTHERAPY. Treatment by occupation.

ERYTHROPHOBIA. Morbid dread of blushing.

ETIOLOGY. Cause of a disease.

EUPHORIA. A feeling of well-being; a mild elation.

EXALTATION. A morbid state of happiness.

EXOGENOUS. Originating outside the body.

EXOPHTHALMUS. Protuding eyes.

EXTROVERSION. The direction of energy to objects in the environment.

EXTROVERT. A person who tends to extroversion.

FANTASY (PHANTASY). Daydreaming.

FEEBLE-MINDEDNESS. Mental deficiency, not amounting to imbecility, yet so pronounced that care, supervision, and control is necessary for protection of those afflicted and others.

FIXATION. An arrest or cessation of the process of development at some childhood level.

FREE ASSOCIATION. Ideas allowed to arise spontaneously without conscious restraint or criticism.

FRIGIDITY. Absence of sexual satisfaction in a female.

FRUSTRATION. The blocking or interference of the satisfaction of a need through some barrier or obstruction.

FUGUE. A flight from reality, and unawareness of one's environment, in which the individual carries out co-ordinated, purposeful movements.

FUROR. Extremely violent outbursts of anger often without provocation.

GENERAL PARALYSIS. See paresis.

GONADS. The sex glands.

GRANDIOSE DELUSIONS. Delusions which take the form of exaggerated statements about the patient's strength, wealth, or power.

HALLUCINATION. Sensation without an object.

- HEBEPHRENIA.** A form of schizophrenia.
- HEBETUDE.** Mental dullness.
- HEMIPLEGIA.** Paralysis of one side of the body.
- HEREDITY.** The genetic process by which physical or mental traits are transmitted from parents to offspring.
- HOMOSEXUALITY.** Sexual perversion toward those of the same sex.
- HYPERKINESIA.** Abnormal motility.
- HYPERMANIA.** Extreme form of excitement sometimes seen in manic psychosis.
- HYPNOGOGIC.** A state of semiconsciousness occurring between sleeping and waking.
- HYPNOSIS.** A condition resembling sleep induced by another person during which the patient responds readily to suggestion.
- HYPOCHONDRIA.** A morbid concern for one's health, with the tendency to ascribe a disease or diseases to one's self from insignificant signs.
- HYPOMANIA.** A mild degree of excitement in manic-depressive psychosis.
- HYSTERIA.** A psychoneurosis in which the symptoms may stimulate a bodily disease, but for which there is not any recognizable organic basis.
- Id.** In psychoanalytic terminology, that portion of the unconscious which contains the instincts.
- IDIOT.** An individual with the mental age of two years or under.
- ILLUSION.** A misinterpreted sense impression.
- IMBECILE.** An individual with a mental age of three to seven years.
- IMPULSE.** The stimulus which sets the mind in action.
- INCHOATIVE.** Beginning; not complete; prodromal.
- INCOHERENCE.** A disturbance in the train of thought in which one idea succeeds another without any apparent connection, and in which the goal idea is never reached.
- INFARCTION.** Area of tissue deprived of blood supply due to the blocking of the blood vessel which supplies that part.
- INFERIORITY COMPLEX.** A feeling that one is not so good or so capable as others.
- INHIBITION.** The blocking or frustration of an impulse.
- INSANITY.** A legal term for mental disease which disables to the extent that the patient is unable to distinguish between right and wrong or realize the nature and consequence of his acts.
- INSIGHT.** Understanding of oneself or of any nervous or mental difficulties one may have.
- INSOMNIA.** Inability to sleep.
- INSTINCTS.** Inborn tendencies to act.
- INTELLIGENCE.** The capacity to learn.
- INTELLIGENCE QUOTIENT.** The ratio of the mental age to the actual

- chronological age multiplied by 100. Normal mentality would be 100. An I.Q. below 70 is usually regarded as feeble-mindedness.
- INTROSPECTION. The act of examining (looking into) one's own thoughts or feelings.
- INTROVERSION. The direction of psychic energy to oneself and one's inner problems.
- INTUITION. Subconscious summation of knowledge and experience.
- INVOLUTION. Period when changes of old age begin to appear, usually from fifty years onward.
- JUDGMENT. The ability to recognize the true relations of ideas.
- JUNG, CARL GUSTAV. A Zurich neurologist who has founded a school of psychoanalysis based on Freud's theories but having several important differences.
- KINESTHESIA. The sense by which muscular movements are perceived.
- KINETIC. Pertaining to movement or energy.
- KLEPTOMANIA. The morbid impulse to steal.
- KNEE JERK. One of the deep reflexes obtained by tapping below the patella.
- KORSAKOFF'S PSYCHOSIS. A mental disorder associated with multiple neuritis and marked by memory defect and confabulation. It is named after Syerгей Syergeyovich Korsakoff (also spelled Sergei Korsakow), Russian neurologist (1854-1900).
- KRAEPELIN, EMIL. An eminent German psychiatrist (1856-1926).
- KRAFFT-EBING, BARON RICHARD VON. An eminent German sexologist (1840-1903).
- KRETSCHMER, ERNST. German psychiatrist.
- KRONFELD, ARTHUR. German psychiatrist, psychotherapist.
- LEPTISOME. Synonym of asthenic type (q.v.).
- LIBIDO. Unnatural sexual desire. In psychoanalysis, the psychic energy associated with the instincts.
- LOGORRHEA. Excessive or abnormal talkativeness.
- MACROCEPHALY. Overdevelopment of the head.
- MALINGERING. The deliberate feigning of mental and physical symptoms of illness with the intention to deceive.
- MANIA. Term used to denote the excited phase of manic-depressive psychosis; also an impulse to perform certain acts, as pyromania.
- MASSELON'S TEST. Requiring a patient to form sentences containing all of a certain group of words, e.g., boys, skate, club, wood, rabbit. Named after Michel Julian Masselon, a French neurologist.
- MATERIALISM. The doctrine that all the facts of existence are the result of the action or interaction of substance or matter.
- MEGALOMANIA. Delusions of personal greatness or exaltation.

MELANCHOLIA. A term formerly used in psychiatry, now limited to involuntional melancholia.

MENTAL AGE. The mental level measured in years and corresponding to the average mentality of children at the year designated, e.g., four, seven, etc.

MENTAL DEFICIENCY. Feeble-mindedness.

MENTAL HYGIENE. The aggregate of measures designed to preserve mental health.

MICROCEPHALY. State of having an abnormally small head.

MONOMANIA. Insanity on a single subject.

MONOPHOBIA. Morbid dread or fear of being alone.

MONOPLEGIA. Paralysis of a single limb or part of the body.

MORAL IMBECILE. British term for psychopathic personality.

MORAL INSANITY. British legal term for the psychopathic personality.

MORON. An individual whose mental age is from seven to twelve years.

MUTISM. Failure to speak over an extended period of time, seen especially in the catatonic form of schizophrenia.

MYOCLONIA. Paroxysmal clonic muscular contraction which does not usually produce movement of the part supplied by the muscle.

MY SOPHOBIA. Morbid fear or dread of contamination and filth.

MYTHOMANIA. Morbid tendency to lie or exaggerate.

NARCISSISM. Self-love often associated with genital excitation.

NECROPHOBIA. Morbid fear of death or dead bodies.

NEED. Need represents (1) certain conditions of the tissues of the body, and (2) the irritation or discomfort which accompanies or follows these tissue states. The translation of need into action is expressed by *motive* and *drive*.

NEGATIVISM. The tendency not to do what is requested (passive) or to do the opposite (active).

NEOLOGISMS. Self-invented words or phrases.

NEUROPATHIC. A rare term which was used in the same sense we now use psychogenesis.

NEUROSIS. See PSYCHONEUROSIS.

NOSOPHOBIA. An exaggerated fear of disease.

NYMPHOMANIA. A morbid, insatiable impulse to heterosexuality in women.

OBSESSION. An idea which morbidly dominates the mind constantly suggesting irrational action (often against desire and will).

OCCASION. Consists of one or more circumstances that give an efficient cause an opportunity to act.

OLIGOPHRENIA. Feeble-mindedness.

ORIENTATION. Correct appreciation of time, place, and persons.

PANIC. The abrupt onset of an overwhelming feeling of terror.

- PARALYSIS AGITANS.** A chronic, progressive disease of the central nervous system characterized by a rhythmical tremor of various muscle groups. Parkinson's Disease (masklike, stiff, expressionless face).
- PARAMNESIA.** A form of memory falsification in which the patient is unable to tell whether his recollections are of real events or dreams.
- PARANOIA.** A chronic form of mental disease characterized by the gradual development of an unchangeable, progressive system of delusions.
- PARANONIA.** Aphasia in which the names of objects seen or felt are not recollected.
- PARAPHONIA.** Morbid alteration of the voice.
- PARAPLEGIA.** Paralysis of the legs.
- PAREISIS.** Weakness usually in the sense of limitation of motion. *General paresis:* syphilis of the central nervous system involving the parenchymatous structure of the brain.
- PARKINSON'S DISEASE.** See PARALYSIS AGITANS.
- PAROLE.** A system of supervision of a patient who is away from the hospital prior to legal discharge; the patient may be returned to the hospital without the necessity of formal court action.
- PATHOLOGY.** The science of the nature of disease.
- PATHOPHOBIA.** Morbid dread or fear of disease.
- PERCEPTION.** The conscious recognition of an external stimulus.
- PERSONALITY.** The aggregate of the physical and mental characteristics that enable the individual to respond in characteristic fashion to different situations and distinguish him from others and give him his own peculiar individuality.
- PHOBIA.** An unreasonable fear which the patient recognizes as illogical but which, nevertheless, persists and governs his actions.
- PHOTOPHOBIA.** An abnormal sensitiveness to light.
- PRESBYOPHRENIA.** Early senile dementia. Alzheimer's Disease.
- PROGNOSIS.** Forecast or estimation of the course, outcome, and duration of an illness.
- PROPULSION.** A tendency to fall forward.
- PSEUDOLOGIA FANTASTICA.** A condition in which the patient tells a story which he believes as true but which is based on phantasy.
- PSEUDOMANIA.** A form of mental disease in which the patient accuses himself of crimes which he has not committed.
- PSYCHE.** Mind, intellect, soul.
- PSYCHIATRIST.** One who studies mental diseases from the diagnostic and therapeutic standpoint.
- PSYCHIATRY.** The study and treatment of mental diseases.
- PSYCHIC.** Pertaining to the mind.
- PSYCHIC TRAUMA.** An emotional shock.
- PSYCHOANALYSIS.** A special branch of psychiatry in which the unconscious mental processes are investigated.

PSYCHOBIOLOGY. The study of the mind, according to the methods of biology.

PSYCHOGENIC. Produced by the mind and its mechanisms, but not due to an organic condition or anatomical injury.

PSYCHOLOGY. The science which deals with the normal mind and mental processes. It is the science of the human personality.

PSYCHONEUROSIS. A mental disorder of psychogenic origin in which symptoms arise from a conflict of high emotional value of which the patient may be conscious or unconscious (in marginal consciousness).

PSYCHOPATH. An individual predisposed to mental disorder.

PSYCHOPATHOLOGY. Pathology of the mind.

PSYCHOSOMATIC. The process by which a mental conflict gains outlet through somatic agencies.

PSYCHOTHERAPY. The treatment of disease by mental methods, suggestion, persuasion, psychoanalysis.

PUDENDAL. Pertaining to or subserving the genitals.

PYKNIC CONSTITUTION (*also* PYCNIC). Refers to a body structure characterized by roundness of contour, amplitude of body cavities, and a plentiful endowment of fat.

PYROMANIA. Morbid impulse to set fire to things.

REGRESSION. A term applied to the retrograde changes which take place in the personality in schizophrenia.

REMISSION. A diminution or abatement of symptoms.

REPRESSION. The process of forcing out of mind some undesirable portion of a complex. Repressions make up the content of the subconscious mind (marginal consciousness).

RESISTANCE. A psychoanalytic term meaning the instinctive opposition displayed toward any attempt to lay bare the unconscious (a manifestation of the repressing forces).

RETARDATION. A term used to indicate a slowing or a delaying of association.

RETROPULSION. A tendency to fall backward.

ROMBERG'S SIGN. Difficulty in standing when the eyes are shut; a sign of locomotor ataxia (*tabes dorsalis*).

RORSCHACH TEST. A method of personality study based on the patient's interpretation of ink blots, named after Herman Rorschach.

SATYRIASIS. Pathological excessive heterosexuality in man.

SCHIZOPHRENIA. A term used synonymously for dementia praecox. Literally means a "splitting of the mind," as the emotional expression does not correspond to the intellectual content.

SEMANTIC DEMENTIA. Term coined by Cleckley for the psychopathic personality.²

SENSATION. The state of awareness which results when a sense organ is

stimulated, and which cannot be analyzed into any elements (Titchener, 1896). In psychophysics, a sensation is the awareness which accompanies the excitation of the brain (Fechner, 1860), and which, though unmeasurable itself, can be approached indirectly by measuring the differences between stimuli and the strength of any given stimulus correlated with any sensation.³

SENSORIUM. The entire sensory apparatus of the body.

SIBLINGS. Brothers and sisters of the same parents.

SOCIOPATH. Synonym for psychopathic personality.

SOMATIC. Pertaining to the organs of the body; to body tissue.

SOMNAMBULISM. Walking, writing, or performing other complex acts while asleep and with no recollection afterward of what was done.

SOMNOLENCE. A condition of drowsiness.

STAMMERING. A spasmodic action of the muscles of speech.

STEREOTYPY. The performance of the same acts in the same manner over and over.

STUPOR. A profound disorder of consciousness in which ordinary impressions are not comprehended and voluntary activity is suspended.

STUTTERING. The repetition of the initial sound of a word.

SUBCONSCIOUS. Not wholly conscious; that portion of the mental life which, for the time being, is outside the general field of attention.

SUBLIMATION. The diversion of the energy derived from a mental conflict into useful channels of conduct.

SUGGESTIBILITY. The quality of being suggestible; acting upon the ideas presented by another.

SUPEREGO. A modification of the ego whose chief function is criticism. It is essentially the same as conscience.

SYMPTOM. A subjective manifestation.

SYNDROME. A group of symptoms associated with a disease and forming together a clinical picture of that disease.

SYPHILOPHOBIA. Unwarranted belief on the part of a patient that he is suffering from syphilis.

TABES DORSALIS. Locomotor ataxia; a syphilitic disease of the spinal cord.

TACHYCARDIA. Rapid heart action.

THROMBOSIS. The clotting of blood within a blood vessel.

TRISMUS. Inability to open the mouth due to tonic spasms of the muscles of mastication.

TWILIGHT STATE. A clouding of consciousness such as occurs for a short period after an epileptic seizure.

UNCONSCIOUS. Psychic material not in the immediate field of awareness.

VAGINISMUS. A painful spasm of the vagina.

VERBIGATION. Stereotyped expression of language. Quite senseless words

and sentences constantly repeated in a striking tone, which is also stereotyped.

VOLITION. The act of exercising the will.

VOYEUR. One who obtains sexual pleasure from looking at the genitals of another.

WASSERMANN, AUGUST VON. A German bacteriologist who originated the laboratory test for syphilis.

FOOTNOTES

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2. Harvey Cleckley, *The Mask of Sanity* (St. Louis: The C. V. Mosby Co., 1941), p. 269.
3. Philip Lawrence Harriman, *The New Dictionary of Psychology* (New York: Philosophical Library, 1947), p. 303.

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